

## **SECTION 10 – REFERENCES**

### **Federal Financial Participation Form and Excel File Instructions**

There are two parts to calculating FFP for use in quarterly program invoices:

- a. Time study activity recording (through the use of forms)
- b. Entering time study data into the FFP calculation file worksheets.

After these steps have been taken the resultant information on the FFP Table from the file can be entered on the quarterly invoice.

### **Time Study Forms**

Two sample forms are included in the FFP file. One captures an entire time study period of one. The other is for use on a weekly basis so each time study period would require 4-5 weekly forms. These specific forms are optional. However, regardless of the time study form that is used, it must contain the following information:

1. Name of staff,
2. Time Study Period,
3. All time the staff is reimbursed for,
4. Clearly identified function codes in 30 minute increments,
5. Each function code identified with a Program code, and
6. Each time study signed by a supervisor-verifying accuracy of the time study.

The following instructions relate to the two sample forms.

### **Monthly Form**

This option utilizes the form entitled **Time Study Survey for FFP Program Claiming**. The Centers for Medicare and Medicaid Services (CMS) has given the states the option of documenting the activities done during a time study month by grouping the functions in one-hour increments and summarizing them on a monthly form. Instructions are as follows:

- Step 1 Complete the header information; time study period (Month/Year), employee name, position/employee number, personnel classification, agency name, unit name, and location of employee.
- Step 2 Identify the program to be assigned to each letter in the Program Coding Scheme.
- Step 3 Enter all the work dates included in the time study month.

- Step 4 At the end of each day, summarize the number of hours worked by function and program code (across). Total the time at the bottom of the column and verify that the total documented equals the time actually worked.
- Step 5 If using the FFP Calculation file furnished by the Children's Medical Services Branch, go to Option 2, Step 5. If not using the FFP Calculation file, transfer rows totals by program to Summary Information at bottom and group by enhanced, non-enhanced, non-claimable, and allocated costs. Perform necessary calculations and prepare invoice.
- Step 6 The supervisor of each staff must sign the time study document, attesting to the accuracy and validity of the time study.

## Weekly Form

This option utilizes the form entitled **Weekly Time Study for Federal Financial Participation** and provides a format for each employee to document their program time in 30 minute increments. Employees complete one of these forms for each week in the time study period.

- Step 1 Complete the header information; time study period (Month/Year), employee name, job title, and location of employee and time base.
- Step 2 Identify the program to be assigned to each letter in the Program Code Scheme and dates.
- Step 3 Enter all dates in the time study week.
- Step 4 Indicate the time worked identified by function and program code (see example). At the end of the week, total the daily information by program and function code in the Summary Information box. The totals of the Summary Information and daily computations are joined by an arrow and should match.
- Step 5 The supervisor of each staff must sign the time study document, attesting to the accuracy and validity of the time study.

## FFP Calculations

While the forms to record FFP are optional, the calculations of the appropriate amounts of FFP to require the use of the CMS-FFP Excel file. In order to perform the necessary calculations use the following instructions:

- Step 6 Pull up the file named **FFP\_CALC** in Microsoft Excel for Office 97 format.
- Step 7 The spreadsheet is divided into three worksheets. They are: **Employee Info**, **Enter Data**, and **Report**. Click the tab labeled **Employee Info**.
  - Line 1 Enter the time study period.
  - Line 2 Enter the name of the employee name.
  - Line 3 Enter the employee's job classification.

- Line 4     Indicate if this person is a Skilled Medical Professional by erasing either the **Yes** or **No**.
- Line 5     Enter the name of each program according to the designation on the staff time study (this may vary person to person).
- Line 6     Enter the FFP factor for each program claiming Title XIX matching dollars (for information on determining the Medi-Cal factor, contact your Administrative Consultant).
- Step 8     Click on the tab labeled **Enter Data**. If you use the weekly time studies, transfer the information from the Summary Information to the appropriate column in each table. (If you use some other form [such as the monthly form], enter information into the column headed **Manual Entry of Totals**). Note that the allocated functions (10 and 12) are listed on the first table and are not associated with any specific program.
- Step 9     Click on the tab labeled **Report**. All information for completing the quarterly invoice is shown on this worksheet. This report should be printed and kept with the time study and supporting documentation in the FFP audit file.
- Step 10    The percentages identified on the report are the ones to use for each individual listed on the budget when invoicing.

1	Time Study Period:	
2	Name of Employee:	
3	Classification:	
4	SPMP?:	

5 Enter Salary and Benefit Information Below if you **do not** identify Program hours on daily Time-Cards.

Quarter's Total Salary:	
Quarter's Total Benefits:	

OR

6 Enter Salary and Benefit Information below if you identify Program hours on daily Time-Cards for the entire invoice period.

Program A Salary:	
Program A Benefits:	
Program B Salary:	
Program B Benefits:	
Program C Salary:	
Program C Benefits:	
Program D Salary:	
Program D Benefits:	
Program E Salary:	
Program E Benefits:	
Program F Salary:	
Program F Benefits:	

7 For purposes of claiming federal match, indicate the **average** percentage of clients in the target population for each program who are Medi-Cal eligibles.

Program A:		Program D:	
Program B:		Program E:	
Program C:		Program F:	

Monthly Summary of FFP Time Study Information

This information is entered from the weekly or monthly time study document.

**Allocated Functions**

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Mo. Totals	Total
10							
12							

**Program A**

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Mo. Totals	Total
1							
2							
3							
4							
5							
6							
7							
8							
9							
11							

**Program B**

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Mo. Totals	Total
1							
2							
3							
4							
5							
6							
7							
8							
9							
11							

**Program C**

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Mo. Totals	Total
1							
2							
3							
4							
5							
6							
7							
8							
9							
11							

Program D

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Mo. Totals	Total
1							
2							
3							
4							
5							
6							
7							
8							
9							
11							

Program E

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Mo. Totals	Total
1							
2							
3							
4							
5							
6							
7							
8							
9							
11							

Program F

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Mo. Totals	Total
1							
2							
3							
4							
5							
6							
7							
8							
9							
11							

# Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2004-05

## FFP Time-Study Calculations

### Monthly Summary of Hours by Program

	Program A	Program B	Program C	Program D	Program E	Program F	Allocated Functions	Total Hours By Function
1	0.0	0.0	0.0	0.0	0.0	0.0		0.0
2	0.0	0.0	0.0	0.0	0.0	0.0		0.0
3	0.0	0.0	0.0	0.0	0.0	0.0		0.0
4	0.0	0.0	0.0	0.0	0.0	0.0		0.0
5	0.0	0.0	0.0	0.0	0.0	0.0		0.0
6	0.0	0.0	0.0	0.0	0.0	0.0		0.0
7	0.0	0.0	0.0	0.0	0.0	0.0		0.0
8	0.0	0.0	0.0	0.0	0.0	0.0		0.0
9	0.0	0.0	0.0	0.0	0.0	0.0		0.0
10								0.0
11	0.0	0.0	0.0	0.0	0.0	0.0		0.0
12								0.0
Totals	0.0	0.0	0.0	0.0	0.0	0.0		0.0

	I. TOTAL HOURS from above table	II. PERCENT OF HOURS Col. I / total dist Col. I	III. ALLOCATE PAID TIME OFF HOURS Col. II x Pd time off	IV. TOTAL HOURS Col. I + Col. III	V. PERCENT OF TOTAL Col. IV / total of Col. IV	VI. PERCENT OF GEN ADMIN Col. V / total of Col. V	VII. ALLOCATE GEN ADMIN HRS Col. VI x New Gen admin hrs	VIII. TOTAL DIR AND ALLOC HOURS Col. IV+VII	IX. PERCENT TO DISTRIBUTE COSTS Col. VIII/total Col. VIII	X. DISTRIBUTE SALARY Col. IX x Salary	XI. DISTRIBUTE BENEFITS Col. IX x Benefits	XI. DISTRIBUTE SALARY (TS info only)	XI. DISTRIBUTE BENEFITS (TS info only)	IX. PERCENT TO DISTRIBUTE COSTS Col. VIII/total Col. VIII
ENHANCED														
Program A	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program B	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program C	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program D	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program E	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program F	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
NON-ENHANCED														
Program A	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program B	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program C	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program D	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program E	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program F	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
NON-CLAIMABLE														
Program A	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program B	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program C	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program D	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program E	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program F	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
GENERAL ADMIN	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL FOR DISTRIBUTION														
PAID TIME OFF	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL HOURS FOR MONTH	0.0													

Time Study Period: January-00

Name of Employee: 0

Classification: 0

The following percentages have been generated for each program:

(For use by agencies **with** daily record of program time for the entire invoice period)

	Enhanced	Non-Enhanced	Not Claimable	Total	Salary	Benefits
Program A	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	\$0.00	\$0.00
Program B	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	\$0.00	\$0.00
Program C	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	\$0.00	\$0.00
Program D	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	\$0.00	\$0.00
Program E	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	\$0.00	\$0.00
Program F	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	\$0.00	\$0.00
<b>Total</b>					<b>\$0.00</b>	<b>\$0.00</b>

Total time spent in each program:

(For use by agencies **without** daily record of program time for entire invoice period)

	Percentage of time worked in Program	Salary	Benefits
Program A	0.0%	\$0.00	\$0.00
Program B	0.0%	\$0.00	\$0.00
Program C	0.0%	\$0.00	\$0.00
Program D	0.0%	\$0.00	\$0.00
Program E	0.0%	\$0.00	\$0.00
Program F	0.0%	\$0.00	\$0.00
	<b>0.0%</b>	<b>\$0.00</b>	<b>\$0.00</b>

## **Staffing Standards for California Children's Services (Historical Document)**

### **I. Background**

In 1992 a mandate to develop staffing standards for county CCS programs was given to a committee of independent CCS county representatives to comply with AB 948, Chapter in 1991 in the Health and Safety Code, Section 123955. The staffing standards and the rationale for their development is contained in the document below. The staffing standards developed by the committee in 1992 have been modified for FY 2000-01 by incorporating the CCS Enhanced Budget staffing requirement into the basis staffing standards.

### **II. Introduction**

A mandate was given to a committee of independent county representatives in order to comply with AB 948, specifically the changes in Section 123955 of the Health and Safety Code. The following apply to the committee's mandate:

123955. (a) The state and the counties shall share in the cost of administration of the California Children's Services program at the local level.

(b)(1) The director shall adopt regulations establishing minimum standards for administration, staffing and local implementation of this article subject to reimbursement by the state.

(b)(2) The standards shall allow necessary flexibility in the administration of county programs, taking into account the variability of county needs and resources, and shall be developed and revised jointly with state and county representatives.

The diversity of independent CCS programs in California made this task extremely difficult. There are presently 26 independent county CCS programs with an active caseload ranging from 300 to 68,000 per county. The counties also vary in their organization structure, staff classifications and the duties and responsibilities assigned to a particular classification. This, in turn, is due to the variation in caseload, availability of personnel, and county policy. Finally, recent program changes, such as the legislatively mandated Due Process, will require an as yet undetermined increase in staff. The development of "standards" in the face of such diversity and uncertainty was problematic.

### **III. A Theoretical Model as Guide**

The deliberations of the committee and the rationale for an approach to the mandate can best be illustrated by applying an "open system" model to the CCS program. A system is a set of interdependent parts designed to achieve a goal. An organization, such as a CCS program, is a system. The characteristic features of an open system are inability to always control the influence of the external environment and an incomplete knowledge of the cause/effect relationships of components within the system. Such a system strives to achieve its goal and to remain viable by self-stabilization or homeostasis. This requires the capability to identify dysfunction within the system and the capability to self-correct. The features of this model and components of the CCS system as they relate to

staffing are illustrated in Figure 1, below. The list of activities under process and outcome measures under output is intended for the purpose of illustration only.

The assumption in the model is that there is relationship between staffing (type, numbers), the activities staff perform, and the outcome (actual or desired). Therefore, the monitoring of outcomes and the review of activities needed to achieve the desired outcome is essential for re-defining the type of staffing and the numbers needed. The open-system model requires that this be a continuous process rather than a one-time formulation of standards. It is a process that continuously monitors its outcome (selected outcome measures are suggested above) and adjusts its staffing and/or activities to achieve the desired outcome in the most efficient manner. Thus, "minimal" standards in this model are those demonstrated to be most cost-effective for goal realization.

#### **IV. Methodology**

The subcommittee approached its task by first reviewing the program's rapidly changing environment and the effect of these changes on staffing needs. Examples of major changes considered included: the increasing complexity of medical technology and the fiscal and regulatory changes affecting program operations. The subcommittee also considered the market variation from county to county in a number of areas: caseload; local availability of funds and personnel; and the duties and responsibilities of personnel within a given category.

After considering these constraints, the subcommittee developed a two-pronged approach. The first was to define certain general principles that were to be uniformly applicable. The second was to develop numerical staffing profiles, which incorporated provisions for flexibility. The development of staffing profiles was more difficult and complicated and the methodology/rationale is presented here in more detail.

The Southern California independent counties had begun, several years earlier, to identify staffing needs for optimum case management. By correlating selected outcome measure with number/type of staff required to achieve these measures, staffing ratios (prorated per 1000 active cases) were developed. It was assumed that these ratios could be applied to most counties except those fewer than 1000 and over 10,000. The initial focus of this committee was to revise these ratios and they were revised upward, more on belief than documented fact, to the point that questions were being raised about their being realistic. A survey was, therefore, undertaken to compare current FTEs with FTEs generated by the Southern California and the committee ratios. A fourth category was added - the county estimate of its staffing needs.

#### **V. Results of the Survey**

The timeline for a response was short and 20 counties completed the survey forms (11 from Northern California and 9 from Southern California). The data are tabulated in Figure 2 (see page 10-16).

- A. Total FTEs in the four categories (current staffing, county estimate of need, FTEs generated by Southern California and the committee ratios) were compared:
  - 1. County estimates were higher than current staffing, but reasonably so.

2. County estimates of FTEs needed correlated most closely with FTEs generated by the Southern California ratios; the correlation was best in counties with an active caseload of 1355-2100; it was less for counties with smaller and larger caseloads. This appears to invalidate the assumption about the broader applicability of the Southern California ratio.
3. FTEs based on committee ratios were higher than FTEs in the other categories. There was a 40 - 400 percent increase over current FTEs.
4. These findings, crude as they were, led to the conclusion that county **estimates of staffing needs** would be the most logical basis for this initial iteration of numerical standards.

B. Caseload

The committee had agreed earlier that **active cases** did not reflect true workload and recommended the use of caseload (or workload) figures, to be defined as follows: "an unduplicated count of the clients and applicants with at least one contact or service during the fiscal year." Because counties were not counting cases in this manner, an interim measure of workload was agreed upon: "open caseload at the beginning of a fiscal year plus all referrals during the same fiscal year."

The survey requested numbers on active cases as well as referrals. However, the figures on the latter were unreliable because many were estimates only or included duplicate counts. Thirteen of the 20 responses were considered to have accurate referral counts and the ratio of referrals to active cases was found to be as follows: range - 0.49 to 1.23; mean - 0.58; median - 0.61; and mode - 0.50, 0.71. These figures suggest that, when the extremes are excluded, the ratio is fairly consistent for most of the counties and active cases can be used in this iteration of the standards as proxy for the caseload. However, in subsequent iterations, caseload, as defined above, is to be used in developing staffing profiles.

C. Staffing Profiles

The committee then focused on identifying patterns in the "county estimates" of FTEs needed. This was done by comparing the following data - range, mean, median, and mode for the various personnel classes. Initially, three profiles or staffing patterns were developed, based on three groupings of counties by caseload.

However, this did not provide sufficient discrimination, particularly for counties with active caseloads over 2600. The committee finally defined the following groups by active caseload:

<b>Group 1:</b>	350-550	<b>Group 5:</b>	3,215-3,306
<b>Group 2:</b>	874-951	<b>Group 6:</b>	5,926-6,882

**Group 3:** 1,355-1,792

**Group 7:** 55,000

**Group 4:** 2,100-2,600

Again, the range, mean, median and mode were calculated for each group and "profiles" were developed for all but Groups 2, 4, and 7. Groups 2 and 4 were Intermediate and group 7 was in a class by itself.

The profiles are presented in Figure 3 (see page 10-17). The committee recognizes the limitation of this study - the very small sample size, particularly when further divided into groups, hence lack of statistical significance. However, there was a pattern to the profiles, and the figures showed considerable consistency and incremental change with the increase in caseload. The only exception was the lack of a pattern for the technical and clerical staff in groups 5 and 6. The larger counties, represented by groups 5 and 6, have a more highly specialized staff with more classification levels within each category. It is believed that, as a result, there is less distinction between the technical and clerical staff and the functions they perform, hence the lack of the pattern that was seen in the smaller counties. For this reason, these two categories are, for groups 6 and 7, combined. In spite of all the inherent drawbacks noted, it is believed that these figures are a logical and reasonable starting point for "standards" for the administration of an open-system program.

## **VI. Staffing Standards**

### **A. Composition of Staff**

The diversity of personnel essential for CCS case management and program operations today is reflected in the requirements specified below. In the application of these qualitative standards, it is essential to keep in mind that, particularly in small counties, an individual may function in several staff categories while in larger counties a more highly specialized staffing is to be expected.

The type of staff shall include, at minimum, the following:

1. A person who has overall responsibility for the direction and operation of the program.
2. A person who has overall responsibility for the day-to-day operation of the program (e.g., budgeting, personnel management, fiscal and claims management, etc.).
3. A physician who has experience and/or interest in health care services to children with complex disabilities shall be available to provide the following services: determine medical eligibility and medical benefits, participate as team member in the case management of complex cases; assist with the preparation of Notices of Action and responses to appeals and Fair Hearing requests; assist with by-report fee determinations;

estimate the cost of care for selected cases; and to assist with other program activities requiring medical input, as needed. The physician may delegate certain functions to a nurse or other health professional, however, direct and on-site consultations well as availability by telephone must be maintained.

4. A nurse (RN or PHN) to provide the following services: determine medical eligibility and/or medical benefits under the overall direction of the physician; determine nursing benefits and related medical supplies; participate in the management of complex cases; and assist, as needed, with other program activities requiring medical input.
5. A physical therapist from the MTU staff to provide services for patients in the general CCS program (i.e., outside the MTU program) such as: determine, under the overall direction of the physician, medical eligibility for the MTU and for inpatient/outpatient rehabilitation; determine DME benefits; participate in the case management of complex cases; and provide consultation to case management staff, as needed.
6. The potential contribution of the MSW professional with a medical background to the case management of CCS clients is well recognized. Due to the selectivity of cases requiring their services, there shall be an MSW in counties with a caseload of 2000 or greater (1300 active cases or more) to perform the following functions: provide direct social work intervention to selected cases; participate in the case management of complex cases; identify community resources; serve as liaison to and provide coordination with referring hospitals, centers, and community agencies; provide consultation to CCS staff as needed.
7. The desirability of a Nutritionist as a member of the health professional team was recognized and such a position may be added (subject to the staffing profile appropriate for the county) but is not required.
8. Account clerks to process claims and determine appropriate payment, as needed.
9. Technical staff to perform non-medical case management functions such as: serve as initial contact with client/family; interpret program to client/family or the provider relative to a specific case; determine financial eligibility/residence; request reports; triage charts to the appropriate health professional, as needed; maintain date files and monitor follow-up; maintain timelines, etc.
10. Clerical staff to provide support to all other program staff. Examples of functions are answering telephone, opening/routing mail, typing, transcribing, photocopying, filing, etc.

B. Staffing Standards (Figure 3)

Staffing profiles, developed as described in IV,C, are the first iteration of the staffing standards, representing the patterns of staffing in county programs

believed to be necessary to carry out the program goals. They are numerical figures for the requisite staff identified in A, above, and are presented in Figure 3 (see page 10-17). The ordering of survey respondents by active caseload produced seven categories. Profiles were developed for four of the groups, with two in intermediate categories and one a special situation due to the extremely large active caseload. These profiles or standards eliminate the extremes in county estimates of staffing needs, specifically inadequate staffing and over staffing. Again, it is worth noting that these profiles or standards are simply the first iteration of a process that requires revision and redesign, as warranted by experience.

## **VII. Use of "Standards" in FY 1992-93 and Beyond**

The need for flexibility and the need to redesign the system on the basis of experience have been stressed throughout this report. To assure that these standards do not violate these basic principles, the following procedures for the use of these standards are outlined.

- A. Each county shall submit a budget that is based on the county's estimate of the staff needed to achieve program goals.
- B. The state CCS program shall review with each county its proposed county budget and determine the amount of state reimbursement as well as Medi-Cal reimbursement. The review shall include compliance with required staff composition, as outlined in VI, A, as well as the numbers of staff in each category (Figure 3).
- C. In determining compliance with the appropriate profile (Figure 3), the following unique circumstances of the county need to be considered:
  1. The availability of personnel in the county and other unique circumstances.
  2. The allocation of tasks among personnel (these may vary, for good reason, from the profile or standard).
  3. Counties that, by virtue of an active caseload, fall into the Intermediate groups, (Groups 2 and 4), may have their budgets evaluated on the basis of the standards for the preceding or succeeding group, as indicated. For example, the midpoint of the active caseload of Group 2 is 912. Counties with an active caseload of 912 or less may be assessed on the staffing standards of Group 1; those with an active caseload higher than 912, may be assessed on the standards of Group 3. However, in keeping with flexibility criterion, judgment and local circumstances are to take precedence in borderline situations, particularly during this initial, learning stage of implementation of the standards.
  4. In **all groups** the budget review is to take into consideration the findings of the latest program review with necessary adjustments to be made, as indicated.

- D. The committee strongly urges that the state Medicaid plan include a provision for CCS reimbursement under the Federal Funding Participation program. The reimbursement is to be based on the number of Medi-Cal beneficiaries served by CCS and also on county staffing in accordance with these standards. The reimbursement for case management requires an accurate count of Medi-Cal beneficiaries, hence state CCS needs to implement, as quickly as possible, the proposal submitted by another county committee for such a count. Eligibility of a county for FFP on the basis of these staffing standards will also be assessed in the budget review process.
- E. These standards are to be reassessed within the next two (2) years. For the next iteration, it is essential that the following procedures be in place:
  - 1. Reporting to the state by counties include caseload, (as defined in IV, B) and subsequent staffing profiles be based on caseload rather than active cases.
  - 2. The reassessment and redesign of the program requires that staffing be considered not in isolation but in relationship to all three components of the system. The next staffing profiles are to be based on such a redesign. This requires the identification of key outcome measure and use of these outcome measures to modify staffing and/or activities.

**Figure 2: County Estimates of FTEs Required (Type and Number of Staff)**

County	Active Cases	Referrals	MD	Nurse	Other Health Prof	Admin	Admin Sec	Asst Admin	Assoc/ Tech Support	Account Staff	Clerks *	Total	Comments
1	340	220	0.1	0.5	0	1.0	0	0	0	1.0	1.0	3.6	
2	340	240	0.15	0.5	0.06	0.75	0	0	1.0	0.6	1.0	4.06	
3	529	264	0.25	0.5	0	0.40	0.1	0	3.0	1.0	1.0	5.6	
4	550	275+	0.05	1.0	0	1.0	0	0	1.0	0.5	0.5	4.05	
5	874	471	0.1	0.1	0	1.0	0	0	2.0	1.0	1.0	5.2	Automated
6	951	996	0.4	1.5	0.4	1.0	0	0	3.5	1.0	3.0	11.0	Partly Automated
7	1,355	1020	0.4	1.0	0.6	1.0	0.25	0	4.0	2.0	2.0	11.0	
8	1,377	1698	0.3	3.0	0	1.0	0	0	3.0	2.0	5.5	15.05	Nurse count includes traditional PHN services to CCS patients
9	1,586	914	0.25	2.0	0.75	0.25	0	0	4.0	3.0	2.0	12.25	
10	1,591	1400	0.75	1.0	1.0	1.0	0	0	3.0	2.0	2.0	10.75	
11	1,792	892	0.30	2.0	0.37	0.6	0	1.0	4.0	2.0	1.0	11.27	Automated
12	2,100	1128	0.50	1.0	2.0	1.0	0	0	6.0	1.5	3.5	15.50	
13	2,600	2100	0.80	1.0	1.0	1.0	0	0	5.0	2.5	5.0	16.30	
14	3,215	1977	0.50	2.0	0.3	1.0	0	0	8.0	3.0	1.0	15.8	Partly Automated
15	3,277	2623	1.0	4.0	1.5	1.0	0	0	10.0	2.0	9.0	28.5	
16	3,306	2394	1.0	3.6	1.15	1.0	1.0	1.0	8.0	3.0	4.0	23.75	
17	5,926	5898	1.0	7.0	2.0	1.0	1.0	1.4	14.0	15.0	19.4	61.80	
18	6,118	3014	1.0	4.0	1.5	1.0	1.0	0.5	4.5	3.0	18.0	34.50	
19	6,882	6032	1.0	6.0	2.25	1.0	1.0	1.0	16.0	4.3	3.0	32.25	Automated
20	68,061	46005	5.0	29.0	25	1.0	1.0	1.0	38.5	9.5	143.0	253.00	Automated

\* Please Note: MTU clerical staff have been excluded from these figures.

Prepared 1992

**Figure 3: County Staffing Profiles (Number of Staff by Personnel Class and Active Cases)**

Active Cases	Personnel <sup>A</sup>									Total
	MD	Nurse	Other Health Prof <sup>B</sup>	Adm	Asst Admin	Admin Sec	Account Clerks	Tech Staff	Clerks <sup>C</sup>	
Group 1: 340-550 (N=4)	0.1-0.15	0.5	0	1.0	0	0	1	1	1	4.6-4.65
Group 2: 874-951 (N=2)	Intermediate									
Group 3: 1,335-1,792 (N=5)	0.3	1.0-2.0	0.5	1.0	0	0	2	4	2	10.8-11.8
Group 4: 2,100-2,000 (N=2)	Intermediate									
Group 5: 3,215-3,306 (N=3)	1.0	3.5	1.5	1.0	0.	0	3	8	4	22
Group 6: 5,926-6,882 (N=3)	1.0	6.0	2.0	1.0	1.0	1.0	4	32 <sup>D</sup>		48
Group 7: 55,000 (N=1) <sup>C</sup>	3.0	26.0	11.0	Special Situation			9	117.4		172.4
				1.0	3.0	2.0				

- Numbers are derived primarily from median, mode data.
- RPT, MSW, Nutritionist (please refer to V/A, staff composition).
- Figures do not include clerical staff for the MTU program.
- No meaningful pattern.
- Figures were developed specifically for this county by making additions, based on needs identified in a program review, to existing staff.



## **The Staffing Matrix and Funding of the Child Health and Disability Prevention Program (Historical Document)**

### **I. Background**

With the transition of the CHDP program to the CHDP Gateway in FY 2002-03, the funding of the local CHDP administrative programs needed to shift correspondingly from expenditures of state-only general funds to those matched through federal participation.

The State convened a workgroup of local CHDP program and state staff in December 2002 to develop a methodology for funding that would be caseload driven and responsive to the fluctuations in target populations and administrative responsibilities. The workgroup analyzed the basic required activities of the CHDP program to assure that Medi-Cal eligible children and youth have an effective access to healthcare resources. Critical functions include seeking out and informing eligible populations about the benefits of prevention and the health care resources available for early and periodic assessments and assuring diagnosis and treatment for any health conditions found as a result of a health assessment through a qualified provider network. Staffing guidelines evolved for these basic program activities using target population, health assessments, and provider data. A statewide survey portrayed the extensive coordination and collaboration among public health department programs and community agencies such as the Women, Infants, and Children (WIC) programs, the Maternal and Child Health programs, Childhood Lead Poisoning Prevention programs, public and private schools, and Head Start and state preschools.

### **II. Program Activities- Staffing Factors and Methodology**

Program activities became the foundational factors in the development of a staffing methodology in which program management and program support were configured.

Staffing methodologies are summarized for Program Activities, Program Management, and Program Support in the following sections.

**Informing/Linking** — Children and their families and caregivers need information about the kind and location of services available to them and the processes for navigating successfully in the health care delivery system, including that of the CHDP Gateway. This information is provided through a variety of methods and locations with individuals and groups and with an expected outcome that eligible populations are provided periodic health assessments.

There are two broad classifications of staff involved in these activities. One is ancillary staff who are paraprofessionals possessing higher levels of knowledge and problem solving capabilities and the other is health professional staff such as dental staff, health educators, nutritionists, physicians, and public health nurses. - Ancillary staff is designated as the index level of staff for the completion of Informing and Linking activities. The determination of the FTE for informing and linking requires knowledge of the estimated total CHDP target population.

**Care Coordination** — Care coordination activities assure that children with the identified conditions are provided the necessary diagnosis and treatment. These

conditions may vary from simple and routine areas of follow-up for vision and dental problems to those that require specialty medical and mental health services-The expected outcome is that children's health needs are addressed in a timely way so that potentially disabling and chronic conditions are prevented. This outcome is obtained through the use of qualified available resources for referral, assisting with scheduling and arranging transportation to appointments. The PHN is designated the index classification for Care Coordination. Other staff, namely ancillary and health professional staff is also active in care coordination activities.

The determination of the FTE for the PHN, Ancillary and Health Professional staff requires knowledge of the total number of health assessments or health screens completed for the designated fiscal year, the number of health assessments completed for Medi-Cal Managed Care Plan members and the percent of health assessments or screens that require follow up.

**Provider Orientation And Training** — CHDP providers are the critical element in California's ability to meet early and periodic screening requirements for Medi-Cal eligible children and youth. Local CHDP program staff assure that participating providers understand the screening and reporting requirements of the CHDP program including the components of a comprehensive health assessment, the importance of comprehensive care and the role of the CHDP program in assisting with care coordination and complex billing problems. A qualified provider network is achieved and maintained through ongoing communication and training found at the local program level.

The PHN is designated the index classification for Provider Orientation and Training. The PHN possesses professional education and training qualifications that allow for the PHN to follow up with the health care provider along with the array of other health professionals such as dental staff, health educator, nutritionist, and physician, when they are available. The determination of the FTE for the PHN and Health Professional staff requires knowledge of the total number of active CHDP providers in the local program area.

**Liaison** — As required by EPSDT, local CHDP programs have cooperative and collaborative agreements with multiple agencies and organizations that share an interest in healthy children and youth. These agreements outline basic areas of responsibility and reinforce consistent messages about the importance of comprehensive coordinated services. Duplicative services are avoided. Through leadership and coordination, local CHDP programs maintain an infrastructure for preventative health care services for children and youth. The health professional inclusive of the PHN is the designated classification for Liaison. The health professional possesses professional education and training qualifications that allow for the purpose of the program to be interpreted and shared with multiple agencies.

The determination of the FTE for the health professional staff as Liaison requires knowledge of the type of Medi-Cal managed care in the local program area, the local public health department programs and the other community and school programs.

**III. Program Management - Staffing Factors and Methodology**

The Program Activities and staff of Informing/Linking, Care Coordination, Provider Orientation and Training, and Liaison are under the leadership and supervision of Program Management. Program Management involves staff that has overall responsibility for the direction and operation of the program in a leadership role. Program Management staff includes Information Technology staff who are responsible for developing and maintaining management information.

The determination of the FTE for the Program Management staff requires knowledge of the total FTEs in the areas of Program Activity.

**IV. Program Support -Staffing Factors and Methodology**

The Program Management staff and Program Activities staff clerical support in the performance of their responsibilities. The determination of the FTE for clerical staff requires knowledge of the total FTEs in Program Activity and Program Management.

**V. Use of Staffing Factors and Methodology in 2003-04 and Beyond**

The staffing factors and methodology were designed to be dynamic with caseload growth in mind. Beginning in FY 2003-04, County/City Local Programs prepared their CHDP No County/City Match budgets using the staffing factors and staffing methodology as outlined.

The CMS Branch has recognized that this methodology will require monitoring and evaluation to assure that the methodology meets the expectations for a dynamic program responsive to shifts in population caseload and available resources.

### **Legislation, Regulations, and Guidelines for CCS**

- a. Federal enabling legislation establishing the provisions and funding related to children with special health care needs.

**Reference:** Title V, Part II of the Social Security Act.

- b. State enabling legislation of the CCS program.

**Reference:** Health and Safety Code, Sections 123800 through 123995.

- c. CCS program regulations that implement, interpret, or make specific the enabling legislation.

**Reference:** California Code of Regulations (CCR), Title 22, Sections 41508 through 42801.

- d. Medi-Cal laws pertaining to managed care plan contracts and prior authorization of services by the director as it related to children with conditions eligible under the CCS program.

**Reference:** Welfare and Institutions Code, Sections 14093, 14093.05, 14094, 14094.1, 14094.2, 14094.3, 14093.05, and 14103.8.

- e. Medi-Cal regulations pertaining to the referral of beneficiaries with a medical or surgical condition which would qualify for services under CCS.

**Reference:** CCR, Title 22, Section 51013.

- f. Department of Education laws pertaining to School Therapy Services as it relates to children with conditions eligible under the CCS program.

**Reference:** Government Code, Sections 7570, 7571, 7572, 7572.5, 7573, 7575, and 7582.

- g. Other state laws which impact many CCS families that may be helpful in the CCS case management process:

1. Immunization reactions

**Reference:** Health and Safety Code, Section 120455.

2. Ventilator-dependent children in foster family homes

**Reference:** Health and Safety Code, Section 1507.5.

- h. Current interpretative releases by State Department of Health Services, CCS program.

1. Numbered Letters for communicating policies and procedures.

2. Non-numbered letters for transmitting information.

## **Selected State Laws Relating to CCS**

The following are selected sections of California laws relating to CCS. These sections have been extracted from California's Health and Safety Code, Government Code, Insurance Code, and Welfare and Institutions Code. For more current and complete information on State laws, please visit the Legislative Counsel of California's website at [www.leginfo.ca.gov/calaw.html](http://www.leginfo.ca.gov/calaw.html).

This section is not all-inclusive. Not included are other State laws, federal laws, State and federal regulations, or provisions of the CCS Manual of Procedures or CCS Numbered Letters.

### **Health and Safety Code Section**

#### **120455. Immunization Reactions; liability for act or omission in administration of immunizing agent to minor**

No person shall be liable for any injury caused by an act or omission in the administration of a vaccine or other immunizing agent to a minor, including the residual effects of the vaccine or immunizing agent, if the immunization is either required by state law, or given as part of an outreach program pursuant to Article 2 (commencing with Section 3395) of Chapter 7 of Division 4, and the act or omission does not constitute willful misconduct or gross negligence.

#### **123800. Title of act**

This article shall be known and may be cited as the Robert W. Crown California Children's Services Act.

#### **123805. Services for physically defective or handicapped minors; powers and duties of department**

The department shall establish and administer a program of services for physically defective or handicapped persons under the age of 21 years, in cooperation with the federal government through its appropriate agency or instrumentality, for the purpose of developing, extending and improving the services. The department shall receive all funds made available to it by the federal government, the state, and its political subdivisions or from other sources. The department shall have power to supervise those services included in the state plan that are not directly administered by the state. The department shall cooperate with the medical, health, nursing and welfare groups and organizations concerned with the program, and any agency of the state charged with the administration of laws providing for vocational rehabilitation of physically handicapped children.

The reference to "the age of 21 years" in this section is unaffected by Section 1 of Chapter 1748 of the Statutes of 1971 or any other provision of that chapter.

#### **123810. Transfer of duties, purposes, responsibilities and jurisdiction**

The department succeeds to and is vested with the duties, purposes, responsibilities, and jurisdiction heretofore exercised by the State Department of Benefit Payments with respect to moneys, funds, and appropriations available to the department for the purposes of processing, audit, and payment of claims received for the purposes of this article.

**123815. Possession and control of records, equipment and supplies**

The department shall have possession and control of all records, papers, equipment, and supplies held for the benefit or use of the Director of Benefit Payments in the performance of his duties, powers, purposes, responsibilities, and jurisdiction that are vested in the department by Section 123810.

**123820. Transfer of officers and employees**

All officers and employees of the Director of Benefit Payments who on July 1, 1978 are serving in the state civil service, other than as temporary employees, and engaged in the performance of a function vested in the department by Section 123810 shall be transferred to the department. The status, positions, and rights of these persons shall not be affected by the transfer and shall be retained by them as officers and employees of the department pursuant to the State Civil Service Act, except as to positions exempt from civil service.

**123822. Claims for services; submission to fiscal intermediary; centralized billing system**

All claims for services provided under this article shall be submitted to the state fiscal intermediary for payment no later than January 1, 1999. The State Department of Health Services shall work in cooperation with the counties to develop a timeline for implementing the centralized billing system. If a department review of those counties participating in the centralized billing system demonstrates that as of January 1, 2000, any county has incurred increased costs as a result of submitting claims for services to the state fiscal intermediary, that county may be exempt from this section.

**123825. Intent**

It is the intent of the Legislature through this article to provide, to the extent practicable, for the necessary medical services required by physically handicapped children whose parents are unable to pay for these services, wholly or in part. This article shall also include the necessary services rendered by the program to physically handicapped children treated in public schools that provide services for physically handicapped children.

**123830. Handicapped child**

"Handicapped child," as used in this article, means a physically defective or handicapped person under the age of 21 years who is in need of services. The director shall establish those conditions coming within a definition of "handicapped child" except as the Legislature may otherwise include in the definition. Phenylketonuria, hyaline membrane disease, cystic fibrosis, and hemophilia shall be among these conditions.

The reference to "the age of 21 years" in this section is unaffected by Section 1 of Chapter 1748 of the Statutes of 1971 or any other provision of that chapter.

**123835. Keeping program abreast of advances in medical science; pilot studies**

The department shall keep the program abreast of advances in medical science, leading to the inclusion of other handicapping conditions and services within the limits of and consistent with the most beneficial use of funds appropriated for this purpose. With the approval of the agency

administrator the department may carry out pilot studies to determine the need for, or the feasibility of, including other handicapping conditions and services in the program within the limits of available funds appropriated for the program.

**123840. Services**

"Services," as used in this article, means any or all of the following:

- (a) Expert diagnosis
- (b) Medical treatment
- (c) Surgical treatment
- (d) Hospital care
- (e) Physical therapy
- (f) Occupational therapy
- (g) Special treatment
- (h) Materials
- (i) Appliances and their upkeep, maintenance, care and transportation
- (j) Maintenance, transportation, or care incidental to any other form of "services"

**123845. California Children's Services program**

"California Children's Services program," as used in this article, means the program of services established and operated pursuant to this article.

**123850. Designation of agency to administer California Children's Services program; standards of local administration**

The board of supervisors of each county shall designate the county department of public health or the county department of social welfare as the designated agency to administer the California Children's Services program. Counties with total population under 200,000 persons may administer the county program independently or jointly with the department. Counties with a total population in excess of 200,000 persons shall administer the county program independently. Except as otherwise provided in this article, the director shall establish standards relating to the local administration and minimum services to be offered by counties in the conduct of the California Children's Services program.

**123855. Case finding; consent of parent or guardian**

The department or designated county agency shall cooperate with, or arrange through, local public or private agencies and providers of medical care to seek out handicapped children, bringing them expert diagnosis near their homes. Case finding shall include, but not be limited to, children with impaired sense of hearing. This section does not give the department or

designated agency power to require medical or other form of physical examination without consent of parent or guardian.

**123860.       Diagnosis for handicapped children**

In accordance with applicable regulations of the United States Children's Bureau, the department and designated county agencies shall provide a diagnosis for handicapped children. Within the limits of available funds, the department and designated local agencies may accept for diagnosis a handicapped child believed to have a severe chronic disease or severe physical handicap, as determined by the director, irrespective of whether the child actually has an eligible medical condition specified in Section 123830. The department shall cause a record to be kept listing all conditions diagnosed by the program and shall publish the information annually, including data on the number and kinds of diagnosed medical conditions that do not come within the definition of "handicapped child" as specified in Section 123830.

**123865.       Application for services**

Whenever the parents or estate of a handicapped child is wholly or partly unable to furnish for the child necessary services, the parents or guardian may apply to the agency of the county that has been designated by the board of supervisors of the county of residence under the terms of Section 123850 to administer the provisions for handicapped children. Residence shall be determined in accordance with the provisions of Section 243 and 244 of the Government Code.<sup>1</sup>

**123870.       Standards of financial eligibility; exception for services under the medical therapy program in public schools; fees**

- a.       The department shall establish uniform standards of financial eligibility for treatment services under the California Children's Services (CCS) program.
  - i.                               Financial eligibility for treatment services under this program shall be limited to persons in families with an adjusted gross income of forty thousand dollars (\$40,000) or less in the most recent tax

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<sup>1</sup>**Government Code, Section 243 and 244:**

**243.**       "Every person has, in law, a residence."

**244.**       "In determining the place of residence the following rules shall be observed:

- (a)       It is the place where one remains when not called elsewhere for labor or other special or temporary purpose, and to which he or she returns in seasons of repose.
- (b)       There can only be one residence.
- (c)       A residence cannot be lost until another is gained.
- (d)       The residence of the parent with whom an unmarried minor child maintains his or her place of abode is the residence of such unmarried minor child.
- (e)       The residence of an unmarried minor who has a parent living cannot be changed by his or her own act.
- (f)       The residence can be changed only by the union of act and intent. A married person shall have the right to retain his or her legal residence in the state of California notwithstanding the legal residence or domicile of his or her spouse."

year, as calculated for California State income tax purposes. If a person is enrolled in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the financial documentation required for that program in Section 2699.6600 of Title 10 of the California Code of Regulations may be used instead of the person's California State income tax return. However, the director may authorize treatment services for persons in families with higher incomes if the estimated cost of care to the family in one year is expected to exceed 20 percent of the family's adjusted gross income.

- ii. Children enrolled in the Healthy Families Program who have a CCS program eligible medical condition under Section 123830, and whose families do not meet the financial eligibility requirement of paragraph (1), shall be deemed financially eligible for CCS program benefits.
- b. Necessary medical therapy treatment services under the California Children's Services program rendered in the public schools shall be exempt from financial eligibility standards and enrollment fee requirements for the services when rendered to any handicapped child whose educational or physical development would be impeded without the services.
- c. All counties shall use the uniform standards for financial eligibility and enrollment fees established by the department. All enrollment fees shall be used in support of the California Children's Services program.
- d. Annually, every family with a child eligible to receive services under this article shall pay a fee of twenty dollars (\$20), that shall be in addition to any other program fees for which the family is liable. This assessment shall not apply to any child who is eligible for full scope Medi-Cal benefits without a share of cost, for children receiving therapy through the California Children's Services program as a related service in their individualized education plans, for children from families having incomes of less than 100 percent of the federal poverty level, or for children covered under the Healthy Families Program.

**123872. Repayment agreement for treatment services**

In addition to the other eligibility requirements set forth in this article, prior to being determined financially eligible for services under this article, the applicant family shall agree to repay the California Children's Services program for any treatment services authorized by the program in an amount not to exceed the proceeds of any judgment, award, or settlement for damages as a result of a lawsuit or pursuant to an agreement relating to a California Children's Services medically eligible condition.

**123875. Determination that handicapped child is eligible for therapy by California Children's Services medical therapy unit conference team; disagreement; further justification**

When the California Children's Service medical therapy unit conference team, based on a medical referral recommending medically necessary occupational or physical therapy in accordance with subdivision (b) of Section 7575 of the Government Code,<sup>2</sup> finds that a handicapped child, as defined in Section 123830, needs medically necessary occupational or physical therapy, that child shall be determined to be eligible for therapy services. If the California Children's Services medical consultant disagrees with the determination of eligibility by the California Children's Services medical therapy unit conference team, the medical consultant shall communicate with the conference team to ask for further justification of its determination, and shall weigh the conference team's arguments in support of its decision in reaching his or her own determination.

This section shall not change eligibility criteria for the California Children's Services programs as described in Sections 123830 and 123860.

This section shall not apply to children diagnosed as specific learning disabled, unless they otherwise meet the eligibility criteria of the California Children's Services.

**123880. Continued eligibility; receipt of treatment services under teaching program**

The department and designated agencies shall not deny eligibility or aid under the California Children's Services program because an otherwise eligible person is receiving treatment services under a teaching program at an accredited medical school facility or accredited school or college of pediatric medicine, whether or not all or part of the treatment services are performed by the staff at the facility, school, or college, provided that treatment services at the facility, school or college are under the general supervision of a California Children's Services program panel physician and surgeon, including a family physician, and podiatrist.

**123885. Panel members; qualifications**

Panel members, as set forth in Section 123880, shall be board-certified and have expertise in the care of children.

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<sup>2</sup>**Government Code, Section 7575(b):**

- (b) The department shall determine whether a California Children's Services eligible pupil, or a pupil with a private medical referral needs medically necessary occupational therapy or physical therapy. A medical referral shall be based on a written report from a licensed physician and surgeon who has examined the pupil. The written report shall include the following:
  - (1) The diagnosed neuromuscular, musculoskeletal, or physical handicapping condition prompting the referral.
  - (2) The referring physician's treatment goals and objectives.
  - (3) The basis for determining the recommended treatment goals and objectives, including how these will ameliorate or improve the pupil's diagnosed condition.
  - (4) The relationship of the medical disability to the pupil's need for special education and related services.
  - (5) Relevant medical records.

**123890. Burn victims; treatment in hospital without separate facilities for children**

- (a) The state department shall not deny a hospital's request to provide treatment to burn victims who are eligible under the California Children's Services program solely on the basis that the hospital does not have separate facilities for child and adult burn victims, provided that the hospital has approval from the department to operate a burn center pursuant to Section 1255.
- (b) Subdivision (a) shall only be applied to burn units located in hospitals where there are no regional burn centers, or any other existing burn center, within an 85-mile radius of the hospital.
- (c) Subdivision (a) shall only apply if the hospital seeking the exemption has a state-approved burn center in operation as of January 1, 1982, and if there is no hospital specializing in children's services within an 85-mile radius of the hospital seeking the subdivision (a) exemption.
- (d) Hospitals having qualified and received a subdivision (a) exemption, shall demonstrate, at the request of the department, that the nursing staff providing burn care to children victims have satisfactorily completed post-graduate training in pediatrics.

**123895. Determination of eligibility; certification for care**

The designated agency shall determine the financial eligibility of the family according to standards established by the department. The agency will also determine if the parents are residents of the county, if the guardian of the child is a resident of the county, or if the emancipated minor is a resident of the county where application for services is made. If the agency finds that the family, guardian, or emancipated minor is a resident of the county and financially eligible for services, it shall make a record of the facts and shall certify this child for care under the program.

**123900. Annual enrollment fee; exemptions; one time start up fee; accounting**

- (a) Beginning September 1, 1991, in addition to any other standards of eligibility pursuant to this article, each family with a child otherwise eligible to receive services under this article shall pay an annual enrollment fee as a requirement for eligibility for services, except as specified in subdivision (f).
- (b) The department shall determine the annual enrollment fee, that shall be a sliding fee scale based upon family size and income, and shall be adjusted by the department to reflect changes in the federal poverty level.
- (c) "Family size" shall include the child, his or her natural or adoptive parents, siblings, and other family members who live together and whose expenses are dependent upon the family income.
- (d) "Family income" for purposes of this article, shall include the total gross income, or their equivalents, of the child and his or her natural or adoptive parents.

- (e) Payment of the enrollment fee is a condition of program participation. The enrollment fee is independent of any other financial obligation to the program.
- (f) The enrollment fee shall not be charged in any of the following cases:
  - (1) The only services required are for diagnosis to determine eligibility for services, or are for medically necessary therapy pursuant to Section 123875.
  - (2) The child is otherwise eligible to receive services and is eligible for full Medi-Cal benefits at the time of application or reapplication.
  - (3) The family of the child otherwise eligible to receive services under this article has a gross annual income of less than 200 percent of the federal poverty level.
  - (4) The family of a child otherwise eligible to receive services under this article who is enrolled in the Healthy Families Program (Part 6.2 [commencing with Section 12693] of Division 2 of the Insurance Code).
- (g) Failure to pay or to arrange for payment of the enrollment fee within 60 days of the due date shall result in disenrollment and ineligibility for coverage of treatment services 60 days after the due date of the required payment.
- (h) The county shall apply the enrollment fee scale established by the department and shall collect the enrollment fee. The county may arrange with the family for periodic payment during the year if a lump-sum payment will be a hardship for the family. The agency director of California Children's Services may, on a case-by-case basis, waive or reduce the amount of a family's enrollment fee if, in the director's judgment, payment of the fee will result in undue hardship.
- (i) By thirty days after the effective date of this section or August 1, 1991, whichever is later, the department shall advance to each county, as a one-time startup amount, five dollars and fifty cents (\$5.50) for each county child who was receiving services under this article on June 30, 1990, and who was not a Medi-Cal beneficiary. This one-time payment shall be in addition to the 4.1 percent of the gross total expenditures for diagnoses, treatment, and therapy by counties allowed under subdivision (c) of Section 123955.
- (j) Each county shall submit to the state, as part of its quarterly claim reimbursement, an accounting of all revenues due and revenues collected as enrollment fees.

**123905. Certification of eligibility; authorization and payment for services; reimbursement**

A county of under 200,000 population, administering its county program jointly with the department, shall forward to the department a statement certifying the family of the handicapped child as financially eligible for treatment services. The department shall authorize necessary services within the limits of available funds. The department shall make payment for services, with reimbursement from the county for its proportionate share as specified in this article.

**123910. Payment for services without certification; furnishing services; gifts and legacies**

The department may, without the possession of a county certification, pay the expenses for services required by any physically handicapped child out of any funds received by it through gift, devise, or bequest or from private, state, federal, or other grant or source.

The department may authorize or contract with any person or institution properly qualified to furnish services to handicapped children. It may pay for services out of any funds appropriated for the purpose or from funds it may receive by gift, devise, or bequest.

The department may receive gifts, legacies, and bequests and expend them for the purpose of this article, but not for administrative expense.

**123915. Direct arrangement for services; agreements with parents for payment of enrollment fee**

When the department provides, or arranges for the provision of, services to physically handicapped children directly, as in the case of nonresident physically handicapped children, it shall enter into an agreement with parents, guardians or persons responsible for the care of handicapped children for payment of the enrollment fee.

**123920. Payment of services for non-resident children; special grants or allotments for costs**

Upon the request of another state or of a federal agency, the department may pay the expenses of services required by any physically handicapped child who is not a resident of the state; provided, that the cost of such services is fully covered by special grants or allotments received from the state or federal agency for that purpose.

**123925. Supervision over services; records**

The department and designated agencies shall maintain surveillance and supervision over the services provided handicapped children under authorization by the program to assure a high quality of service and shall cause a record to be kept showing the condition and improvement of these handicapped children.

**123930. Consent of parent or guardian; exception**

This article does not authorize any treatment service without the written consent of a parent or guardian except as a person under 18 years of age is an emancipated minor.

**123935. Effect of mental retardation**

A handicapped child shall not be denied services pursuant to this article because he or she is mentally retarded.

**123940. County appropriations and expenditures; state matching**

(a)

- (1) Annually, the board of supervisors shall appropriate a sum of money for services for handicapped children of the county, including diagnosis, treatment, and therapy services for physically handicapped children in public schools, equal to 25 percent of the actual expenditures for the county program under this article for the 1990-1991 fiscal year, except as specified in paragraph (2).
  - (2) If the state certifies that a smaller amount is needed in order for the county to pay 25 percent of costs of the county's program from this source. The smaller amount certified by the state shall be the amount that the county shall appropriate.
- (b) In addition to the amount required by subdivision (a), the county shall allocate an amount equal to the amount determined pursuant to subdivision (a) for purposes of this article from revenues allocated to the county pursuant to Chapter 6 (commencing with Section 17600) of Division 9 of the Welfare and Institutions Code.
- (c)
  - (1) The state shall match county expenditures for this article from funding provided pursuant to subdivisions (a) and (b).
  - (2) County expenditures shall be waived for payment of services for children who are eligible pursuant to paragraph (2) of subdivision (a) of Section 123870.
- (d) The county may appropriate and expend moneys in addition to those set forth in subdivisions (a) and (b) and the state shall match the expenditures, on a dollar-for-dollar basis, to the extent that state funds are available for this article.
- (e) Nothing in this section shall require the county to expend more than the amount set forth in subdivision (a) plus the amount set forth in subdivision (b) nor shall it require the state to expend more than the amount of the match set forth in subdivision (c).

**123945. State emergency aid**

For those counties with a total appropriation of county funds not exceeding one hundred and twenty-five thousand dollars (\$125,000) and upon the expenditure of the county funds equivalent to a county appropriation pursuant to Section 123940, the department may, to the extent funds are available from state appropriated funds for the California Children's Services program and upon certification of the county that there are insufficient revenues from the account established pursuant to Chapter 6 (commencing with Section 17600) of Division 9 of the Welfare and Institutions Code, pay for services for cases deemed by the department to represent emergencies or cases where medical care cannot be delayed without great harm to the child.

**123950. Administration of medical-therapy program; cost; standards; regulations**

The designated county agency shall administer the medical-therapy program in local public schools for physically handicapped children. As provided in Section 123940, the state and

counties will share in the cost of support of therapist salaries in these schools in the ratio of one dollar (\$1) of state or federal funds reimbursed quarterly to one dollar (\$1) of county funds. The director shall establish standards for the maximum number of therapists employed in the schools eligible for state financial support in this program, the services to be provided, and the county administrative services subject to reimbursement by the state.

The department may adopt regulations to implement this section as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the purposes of the Administrative Procedure Act, the adoption of the regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, and general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, these emergency regulations shall not be subject to the review and approval of the Office of Administrative Law.

Notwithstanding any other provision of law, if the department determines that emergency regulations are necessary to implement any part of this article, there shall be deemed to be good cause for the regulations to take effect prior to public notice and hearing.

Notwithstanding subdivision (h) of Section 11346.1 and Section 11349.6 of the Government Code, the department shall transmit these regulations directly to the Secretary of State for filing. The regulations shall become effective immediately upon filing by the Secretary of State.

The Office of Administrative Law shall provide for the printing and publication of these regulations in the California Code of Regulations. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, these regulations shall not be repealed by the Office of Administrative Law and shall remain in effect until revised or repealed by the department.

**123955. California Children's Services program; sharing costs; standards**

- (a) The state and the counties shall share in the cost of administration of the California Children's Services program at the local level.
- (b)
  - (1) The director shall adopt regulations establishing minimum standards for the administration, staffing, and local implementation of this article subject to reimbursement by the state.
  - (2) The standards shall allow necessary flexibility in the administration of county programs, taking into account the variability of county needs and resources, and shall be developed and revised jointly with state and county representatives.
- (c) The director shall establish minimum standards for administration, staffing and local operation of the program subject to reimbursement by the state.
- (d) Until July 1, 1992, reimbursable administrative costs, to be paid by the state to counties, shall not exceed 4.1 percent of the gross total expenditures for diagnosis, treatment and therapy by counties as specified in Section 123940.

- (e) Beginning July 1, 1992, this subdivision shall apply with respect to all of the following:
  - (1) Counties shall be reimbursed by the state for 50 percent of the amount required to meet state administrative standards for that portion of the county caseload under this article that is ineligible for Medi-Cal to the extent funds are available in the state budget for the California Children's Services program.
  - (2) On or before September 15 of each year, each county program implementing this article shall submit an application for the subsequent fiscal year that provides information as required by the state to determine if the county administrative staff and budget meet state standards.
  - (3) The state shall determine the maximum amount of state funds available for each county from state funds appropriated for CCS county administration. If the amount appropriated for any fiscal year in the Budget Act for county administration under this article differs from the amounts approved by the department, each county shall submit a revised application in a form and at the time specified by the department.
- (f) The department and counties shall maximize the use of federal funds for administration, of the programs implemented pursuant to this article, including using state and county funds to match funds claimable under Title 19 of the Social Security Act.

**123960. Program data; purposes**

The department shall require of participating local governments the provision of program data including, but not limited to, the number of children treated, the kinds of disabilities, and the costs of treatment, to enable the department, the Department of Finance, and the Legislature to evaluate in a timely fashion and to adequately fund the California Children's Services program.

**123965. Placement of handicapped children for adoption; entitlement to services**

A handicapped child placed for adoption, determined to be financially eligible for care at the time of placement, shall not be denied services pursuant to this article based upon the income of the adopting parents, nor shall the adopting parents be required to enter into any agreement to pay toward the costs of services authorized for the care. This section shall only apply to physical handicaps present, and diagnosed, at the time of adoption. Residence, for the purposes of this section, shall be that of the adopting parents.

**123970. Notification of prospective adopting parents; termination of program funds**

The department and the placing adoption agency at the time of placement shall notify all prospective adopting parents in writing, that funds received under the California Children's Services program shall terminate if the adopting parents move out of the state. However, the department and the placing adoption agency shall advise the prospective adopting parents that they may be eligible for the funds in the new state, subject to any applicable qualifications.

**123975. Screening newborn infants for deafness; follow up and assessment**

- (a) The department, in consultation with selected representatives of participating neonatal intensive care units, shall establish a system to screen newborn infants at high risk for deafness and create and maintain a system of follow up and assessment for infants identified by such screening in neonatal intensive care units participating in the California Children's Services program.

This section shall not be applicable to a newborn child whose parent or guardian objects to the tests on the ground that the tests conflict with his or her religious beliefs or practices.

- (b) It is the intent of the Legislature, in enacting this section, to ensure the establishment and maintenance of protocols and quality of standards.
- (c) The department shall implement this section for infants in neonatal intensive care units participating in the California Children's Services program.

**123980. Actions against third persons liable for injury; notice**

If the recipient of services provided by the California Children's Services program, his or her guardian, conservator, personal representative, estate, or survivors, or any of them brings an action against a third person who may be liable for the injury, notice of institution of legal proceedings, notice of settlement, and all other notices required by this code shall be given to the State Director of Health Services in Sacramento and to the county-managed California Children's Services program. The director may provide notice to the Attorney General. All of these notices shall be given by the attorney retained to assert the beneficiary's claim, or by the injured party beneficiary, his or her guardian, conservator, personal representative, estate, or survivors, if no attorney is retained.

**123982. Treatment provided under children's services program; claim against judgment, award or settlement received against third-party; liens**

Except as otherwise provided by law, the amount of any judgment, award, or settlement relating to a medical condition for which treatment services have been provided under the California Children's Services program shall be subject to a claim by the state department and the designated county agency for reimbursement of the costs of the benefits provided, and to any lien filed against that judgment, award, or settlement. The department or the county designated agency, through its civil legal adviser, may, to enforce this right, institute and prosecute legal proceedings against the person who has received benefits under this article, his or her guardian, conservator, or other personal representative, or his or her estate. In the event of a judgment, award, or settlement in a suit or claim against a third person who is liable for the medical condition for which treatment services have been provided under the California Children's Services program, the court or other agency shall first order paid from the judgment, award, or settlement the actual costs of the care and treatment furnished, or to be furnished, under the California Children's Services program.

**123985. Bone marrow transplant; reimbursement; conditions**

- (a) A bone marrow transplant for the treatment of cancer shall be reimbursable under this article, when all of the following conditions are met:

- (1) The bone marrow transplant is recommended by the recipient's attending physician.
  - (2) The bone marrow transplant is performed in a hospital that is approved for participation in the California Children's Services program.
  - (3) The bone marrow transplant is a reasonable course of treatment and is approved by the appropriate hospital medical policy committee.
  - (4) The bone marrow transplant has been deemed appropriate for the recipient by the program's medical consultant. The medical consultant shall not disapprove the bone marrow transplant solely on the basis that it is classified as experimental or investigational.
- (b) The program shall provide reimbursement for both donor and recipient surgery.
  - (c) Any county that has a population of not more than 600,000, as determined by the most recent decennial census conducted by the United States Bureau of the Census, shall be exempt from complying with the 25-percent matching requirement provided for under this article, for any bone marrow transplant reimbursable under this section.

**123990. Adoption of regulations; authority of department**

The department shall adopt regulations to implement the amendments of this article in 1991. The adoption of the regulations shall be deemed to be an emergency, and necessary for the immediate preservation of the public peace, health, safety, and general welfare.

**123995. Medi-Cal application requirements**

- (a) The department shall require all applicants to the program who may be eligible for cash grant assistance or for Medi-Cal benefits to apply for Medi-Cal.
- (b) This section shall not be interpreted to prohibit the coverage of services in emergency cases.

**Government Code Sections (Re: School Therapy Services)**

**7570. Maximum utilization of resources**

Ensuring maximum utilization of all state and federal resources available to provide children and youth disabilities, as defined in subsection (1) of the Section 1401 of Title 20 of the United States Code, with a free appropriate public education, the provision of related services, as defined in Subsection (17) of Section 1401 of Title 20 of the United States Code and designated instruction and services, as defined in Section 56363 of the Education Code, to children and youth with disabilities, shall be the joint responsibility of the Superintendent of Public Instruction and the Secretary of Health and Welfare. The Superintendent of Public Instruction shall ensure that this chapter is carried out through monitoring and supervision.

**7571. Assumption of responsibilities; department and county agencies to be designated**

The Secretary of Health and Welfare may designate a department of state government to assume the responsibilities described in Section 7570. The secretary, or his or her designee, shall also designate a single agency in each county to coordinate the service responsibilities described in Section 7572.

**7572. Assessments; provision of related services or designated instruction and services**

- (a) A child shall be assessed in all areas related to the suspected disability by those qualified to make a determination of the child's need for the service before any action is taken with respect to the provision of related services or designated instruction and services to a child, including, but not limited to, services in the areas of, occupational therapy, physical therapy, psychotherapy, and other mental health assessments. All assessments required or conducted pursuant to this section shall be governed by the assessment procedures contained in Article 2 (commencing with Section 56320) of Chapter 4 of Part 30 of the Education Code.
- (b) Occupational therapy and physical therapy assessments shall be conducted by qualified medical personnel as specified in regulations developed by the State Department of Health Services in consultation with the State Department of Education.
- (c) Psychotherapy and other mental health assessments shall be conducted by qualified mental health professionals as specified in regulations developed by the State Department of Mental Health, in consultation with the State Department of Education, pursuant to this chapter.
- (d) A related service or designated instruction and service shall only be added to the child's individualized education program by the individualized education program team, as described in Part 30 (commencing with Section 56000) of the Education Code, if a formal assessment has been conducted pursuant to this section, and a qualified person conducting the assessment recommended the service in order for the child to benefit from special education. In no case shall the inclusion of necessary related services in a pupil's individualized education plan be contingent upon identifying the funding source. Nothing in this section shall prevent a parent from obtaining an independent assessment in accordance with subdivision (b) of Section 56329 of the Education Code, which shall be considered by the individualized education program team.
  - (1) Whenever an assessment has been conducted pursuant to subdivision (b) or (c), the recommendation of the person who conducted the assessment shall be reviewed and discussed with the parent and with appropriate members of the individualized education program team prior to the meeting of the individualized education program team. When the proposed recommendation of the person has been discussed with the parent and there is disagreement on the recommendation pertaining to the related service, the parent shall be notified in writing and may require the person who conducted the assessment to attend the individualized education program team meeting to discuss the recommendation. The person who conducted the assessment shall attend the individualized

education program team meeting if requested. Following this discussion and review, the recommendation of the individualized education program team members who are attending on behalf of the local educational agency.

- (2) If an independent assessment for the provision of related services or designated instruction and services is submitted to the individualized education program team, review of that assessment shall be conducted by the person specified in subdivisions (b) and (c). The recommendation of the person who reviewed the independent assessment shall be reviewed and discussed with the parent and with appropriate members of the individualized education program team prior to the meeting of the individualized education program team. The parent shall be notified in writing and may request the person who reviewed the independent assessment to attend the individualized education program team meeting to discuss the recommendation. The person who reviewed the independent assessment shall attend the individualized education program team meeting if requested. Following this review and discussion, the recommendation of the person who reviewed the independent assessment shall be the recommendation of the individualized education program team members who are attending on behalf of the local agency.
- (3) Any disputes between the parent and team members representing the public agencies regarding a recommendation made in accordance with paragraphs (1) and (2) shall be resolved pursuant to Chapter 5 (commencing with Section 56500) of Part 30 of the Education Code.
- (e) Whenever a related service of designated instruction and service specified in subdivision (b) or (c) is to be considered for inclusion in the child's individualized education program, the local education agency shall invite the responsible public agency representative to meet the individualized education program team to determine the need for the service and participate in developing the individualized education program. If the responsible public agency representative cannot meet the individualized education program team, then the representative shall provide written information concerning the need for the service pursuant to subdivision (d). Conference calls, together with written recommendations, are acceptable forms of participation. If the responsible public agency representative will not be available to participate in the individualized education program meeting, the local educational agency shall ensure that a qualified substitute is available to explain and interpret the evaluation pursuant to subdivision (d) of Section 56341 of the Education Code. A copy of the information shall be provided by the responsible public agency to the parents or any adult pupil for whom no guardian or conservator has been appointed.

### **7573. Special education and related services**

The Superintendent of Public Instruction shall ensure that local education agencies provide special education and those related services and designated instruction and services contained in a child's individualized education program that are necessary for the child to benefit educationally from his or her instructional program. Local education agencies shall be responsible only for the provision of those services which are provided by qualified personnel

whose employment standards are covered by the Education Code and implementing regulations.

**7575. Occupational therapy and physical therapy**

- (a)
  - (1) Notwithstanding any other provision of law, the State Department of Health Services, or any designated local agency administering the California Children's Services, shall be responsible for the provision of medically necessary occupational therapy and physical therapy, as specified by Article 2 (commencing with Section 248) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, by reason of medical diagnosis and when contained in the child's individualized education program.
  - (2) Related services or designated instruction and services not deemed to be medically necessary by the State Department of Health Services, which the individualized education program team determines are necessary in order to assist a child to benefit from special education, shall be provided by the local education agency by qualified personnel whose employment standards are covered by the Education Code and implementing regulations.
- (b) The department shall determine whether a California Children's Services eligible pupil, or a pupil with a private medical referral needs medically necessary occupational therapy or physical therapy. A medical referral shall be based on a written report from a licensed physician and surgeon who has examined the pupil. The written report shall include the following:
  - (1) The diagnosed neuromuscular, musculoskeletal, or physical disabling condition prompting the referral.
  - (2) The referring physician's treatment goals and objectives.
  - (3) The basis for determining the recommended treatment goals and objectives, including how these will ameliorate or improve the pupil's diagnosed condition.
  - (4) The relationship of the medical disability to the pupil's need for special education and related services.
  - (5) Relevant medical records.
- (c) The department shall provide the service directly or by contracting with another public agency, qualified individual, or a state-certified nonpublic nonsectarian school or agency.
- (d) Local education agencies shall provide necessary space and equipment for the provision of occupational therapy and physical therapy in the most efficient and effective manner.

- (e) The department shall also be responsible for providing the services of a home health aide when the local education agency considers a less restrictive placement from home to school for a pupil for whom both of the following conditions exist:
  - (1) The California Medical Assistance Program provides a life-supporting medical service via a home health agency during the time in which the pupil would be in school or traveling between school and home.
  - (2) The medical service provided requires that the pupil receive the personal assistance or attention of a nurse, home health aide, parent or guardian, or some other specially trained adult in order to be effectively delivered.

**7582. Assessment and therapy treatment services; exemption from financial eligibility standards**

Assessment and therapy treatment services provided under programs of the State Department of Health Services or the State Department of Mental Health, or their designated local agencies, rendered to a child referred by a local education agency for an assessment or a handicapped child with an individualized education program, shall be exempt from financial eligibility standards and family repayment requirements for these services when rendered pursuant to this chapter.

**Insurance Code (Re: Healthy Families)**

**“CCS Carve-out related to HF Health Benefits”**

**12693.62. California Children's Services program; plan responsibility for services to eligible subscribers; referral of children; case management**

Notwithstanding any other provision of law, for a subscriber who is determined by the California Children's Services program to be eligible for benefits under the program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, a participating plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services program for the particular subscriber for the treatment of a California Children's Services program eligible medical condition. Participating plans shall refer a child who they reasonably suspect of having a medical condition that is eligible for services under the California Children's Services program to the California Children's Services program. The California Children's Services program shall provide case management and authorization of services if the child is found to be medically eligible for the California Children's Services program. Diagnosis and treatment services that are authorized by the California Children's Services program shall be performed by paneled providers for that program and approved special care centers of that program in accordance with treatment plans approved by the California Children's Services program. All other services provided under the participating plan shall be available to the subscriber.

**“CCS Carve-out related to HF Dental Benefits”**

**12693.64. California Children's Services program; plan responsibility for services to eligible subscribers**

Notwithstanding any other provision of law, for a subscriber who is determined by the California Children's Services program to be eligible for benefits under the program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, a participating plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services program for the particular subscriber for the treatment of a California Children's Services program eligible medical condition. All other services provided under the participating plan shall be available to the subscriber.

**“CCS Carve-out related to HF Vision Benefits”**

**12693.66. California Children's Services program; plan responsibility for services to eligible subscribers**

Notwithstanding any other provision of law, for a subscriber who is determined by the California Children's Services program to be eligible for benefits under the program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, a participating plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services program for the particular subscriber for the treatment of a California Children's Services program eligible medical condition. All other services provided under the participating plan shall be available to the subscriber.

**“CCS County Expenditure Exemption”**

**12693.69. Child enrolled in Health Families Program; eligibility for services under California Children's Services program**

A child enrolled in the Healthy Families Program who has a medical condition that is eligible for services pursuant to the California Children's Services program, and whose family is not financially eligible for the California Children's Services program, shall have the medically necessary treatment services for their California Children's Services program eligible medical condition authorized and paid for by the California Children's Services program. County expenditures for the payment of services for the child shall be waived and these expenditures shall be paid for by the state from Title XXI funds that are applicable and state general funds.

**Welfare and Institutions Code (Re: Medi-Cal Managed Care Contract Laws)**

**14093. Purpose**

The purpose of this article is to ensure quality of care and to provide increased access to health care services in the most cost-effective and efficient manner possible, to persons who are eligible to receive medical benefits under publicly supported programs other than Medi-Cal.

**14093.05. Establishment of contract; amendment of existing Medi-Cal managed care contracts; agreement to hold beneficiaries of publicly supported programs harmless; managed care contractors serving children; standards of care; report of expenditures and savings; reduction in benefits**

- (a) The director shall enter into contracts with managed care plans under this chapter and Chapter 8 (commencing with Section 14200), including, but not

limited to, health maintenance organizations, prepaid health plans, and primary care case management plans; counties, primary care providers, independent practice associations, private foundations, children's hospitals, community health centers, rural health centers, community clinics, and university medical center systems, or other entities for the provision of medical benefits to all persons who are eligible to receive medical benefits under publicly supported programs. The director may also amend existing Medi-Cal managed care contracts to include the provision of medical benefits to persons who are eligible to receive medical benefits under publicly supported programs. Contracts may be on an exclusive or nonexclusive basis.

- (b) Contractors pursuant to this article and participating providers acting pursuant to subcontracts with those contractors, shall agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the contractor does not ensure sufficient funding to cover program benefits.
- (c) Any managed care contractor serving children with conditions eligible under the California Children's Services (CCS) program shall maintain and follow standards of care established by the program, including use of paneled providers and CCS-approved special care centers and shall follow treatment plans approved by the program, including specified services and providers of services. If there are insufficient paneled providers willing to enter into contracts with the managed care contractor, the program shall seek to establish new paneled providers willing to contract. If a paneled provider cannot be found, the managed care contractor shall seek program approval to use a specific non-paneled provider with appropriate qualifications.
- (d)
  - (1) Any managed care contractor serving children with conditions eligible under the CCS program shall report expenditures and savings separately for CCS covered services and CCS eligible children.
  - (2) If the managed care contractor is paid according to a capitated or risk-based payment methodology, there shall be a separate actuarially sound rates for CCS eligible children.
  - (3) Notwithstanding paragraph (2), a managed care pilot project may, if approval is obtained from the State CCS program director, utilize an alternative rate structure for CCS eligible children.
- (e) This article is not intended to and shall not be interpreted to permit any reduction in benefits or eligibility levels under the CCS program. Any medically necessary service not available under the managed care contracts authorized under this article shall remain the responsibility of the state and county.
- (f) To assure CCS benefits are provided to enrollees with a CCS eligible condition according to CCS program standards, there shall be oversight by the state and local CCS program agencies for both services covered and not covered by the managed care contract.

- (g) Any managed care contract which will effect the delivery of care to CCS eligible children shall be approved by the state CCS program director prior to execution. The state CCS program shall continue to be responsible for selection of CCS paneled providers and monitoring of contractors to see that CCS state standards are maintained.

**Article 2.98. California Children's Services program and Medi-Cal Managed Care Contracts**

**14094. CCS**

For purposes of this article "CCS" means California Children's Services.

**14904.1. Managed care contractors; Standards of care; use of panel providers; report of expenditures and savings; payment according to capitated payment methodology**

- (a) The director shall investigate and to the extent feasible require any managed care contractor serving children with conditions eligible under the CCS program, to maintain and follow standards of care established by the program, including use of paneled providers and CCS approved special care centers and to follow treatment plans approved by the program, including specified services and providers of services. If there are insufficient paneled providers willing to enter into contracts with the managed care contractor, the program shall seek to establish new paneled providers willing to contract. If a paneled provider cannot be found, the managed care contractor shall seek program approval to use a specific nonpaneled provider with appropriate qualifications.
- (b) The director shall investigate and to the extent feasible require any managed care contractor serving children with conditions eligible under the CCS program, to report expenditures and savings separately for CCS covered services and CCS eligible children.
- (c)
  - (1) If the managed care contractor is paid according to a capitated or risk-based payment methodology, there shall be a separate actuarially sound rate for CCS eligible children.
  - (2) Notwithstanding paragraph (1), a managed care pilot project may, if approval is obtained from the state CCS program director, utilize an alternative rate structure for CCS eligible children.

**14094.2. Medically necessary services not available under managed care contracts; state and county responsibility**

- (a) This article is not intended, and shall not be interpreted, to permit any reduction in benefits or eligibility levels under the CCS program. Any medically necessary service not available under the managed care contracts authorized under this article shall remain the responsibility of the state and county.

- (b) In order to ensure that CCS benefits are provided to enrollees with a CCS eligible condition according to CCS program standards, there shall be oversight by the state and local CCS program agencies for both services covered and not covered by the managed care contract.

**14094.3. Incorporation of CCS covered services into Medi-Cal managed care contracts; time; fee-for-service billing prior to incorporation; pilot projects**

- (a) Notwithstanding this article or Section 14093.05 or 14094.1, CCS covered services shall not be incorporated into any Medi-Cal managed care contract entered into after August 1, 1994, pursuant to Article 2.7(commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.9 (commencing with Section 14088), Article 2.91 (commencing with Section 14089), Article 2.95 (commencing with Section 14092); or either Article 2 (commencing with Section 14200), or Article 7 (commencing with Section 14490) of Chapter 8, until three years after the effective date of the contract.
- (b) Notwithstanding any other provision of this chapter, providers serving children under the CCS program who are enrolled with a Medi-Cal managed care contractor but who are not enrolled in a pilot project pursuant to subdivision (c) shall continue to submit billing for CCS covered services on a fee-for-service basis until CCS covered services are incorporated into the Medi-Cal managed care contracts described in subdivision (a).
- (c)
  - (1) The department may authorize a pilot project in Solano County in which reimbursement for conditions eligible under the CCS program may be reimbursed on a capitated basis pursuant to Section 14093.05, and provided all CCS program's guidelines, standards, and regulations are adhered to, and CCS program's case management is utilized.
  - (2) During the three-year time period described in subdivision (a), the department may approve, implement, and evaluate limited pilot projects under the CCS program to test alternative managed care models tailored to the special health care needs of children under the CCS program. The pilot projects may include, but need not be limited to, coverage of different geographic areas, focusing on certain subpopulations, and the employment of different payment and incentive models. Pilot project proposals from CCS program-approved providers shall be given preference. All pilot projects shall utilize CCS program-approved standards and providers pursuant to Section 14094.1.
- (d)
  - (1) The department shall submit to the appropriate committees of the Legislature an evaluation of pilot projects established pursuant to subdivision (c) based on at least one full year of operation.

- (2) The evaluation required by paragraph (1) shall address the impact of the pilot projects on outcomes as set forth in paragraph (4) and, in addition, shall do both of the following:
  - (A) Examine the barriers, if any, to incorporating CCS covered services into the Medi-Cal managed care contracts described in subdivision (a).
  - (B) Compare different pilot project models with the fee-for-service system. The evaluation shall identify, to the extent possible, those factors that make pilot projects most effective in meeting the special needs of children with CCS eligible conditions.
- (3) CCS covered services shall not be incorporated into the Medi-Cal managed care contracts described in subdivision (a) before the evaluation process has been completed.
- (4) The pilot projects shall be evaluated to determine if:
  - (A) All children enrolled with a Medi-Cal managed care contractor described in subdivision (a) identified as having a CCS eligible condition are referred in a timely fashion for appropriate health care.
  - (B) All children in the CCS program have access to coordinated care that includes primary care services in their own community.
  - (C) CCS program standards are adhered to.
- (e) For purposes of this section, CCS covered services include all program benefits administered by the program specified in Section 251 of the Health and Safety Code regardless of the funding source.
- (f) Nothing in this section shall be construed to exclude or restrict CCS eligible children from enrollment with a managed care contractor or from receiving from the managed care contractor with which they are enrolled primary and other health care unrelated to the treatment of the CCS eligible condition.

## **Legislation, Regulations, and Guidelines for the CHDP Program**

A. Enabling legislation of the CHDP program

**Reference:** Health and Safety Code, Sections 104395, 105300, 105305, 120475, and 124025 through 124110.

B. CHDP program regulations that implement, interpret, or make specific the enabling legislation.

**Reference:** California Code of Regulations (CCR), Title 17, Sections 6800 through 6874.

C. Medi-Cal regulations pertaining to the availability and reimbursement of EPSDT services through the CHDP program.

**Reference:** CCR, Title 22, Sections 51340 and 51532.

D. Regulations defining county Social Services Department responsibilities for meeting CHDP/EPSDT Program requirements.

1. Social Services Regulations

- a. Staff Development and Training Standards - Manual of Policies and Procedures (MPP) Section 14-530 and 14-610.
- b. Civil Rights - MPP Sections 21-101, 21-107, and 21-115.
- c. Eligibility and Assistance Standards - MPP Sections 40-107.61, 40-131.3(k), 40-181.211, and 45-201.5.
- d. Child Welfare Services Program Standards: MPP Sections 31-002(c)(8), 31-075.3(h)(1), 31-075.3(h)(2), 31-205.18, 31-206.35, 31-206.351, 31-206.352, 31-206.36, 31-206.361, 31-206.362, 31-206.42, 31-206.421, 31-206.422, 31-330.111, 31-401.4, 31-401.41, 31-401.412, 31-401.413, 31-405.1(f), 31-405.1(g), and 31-405.1(g)(1).
- e. Intra and Interagency relations and agreements Chapters 29-405 and 29-410.

2. Medi-Cal Regulations

**Reference:** CCR, Title 22, Sections 50031; 50157(a), (d), (e), and (f) and 50184(b).

E. Current Interpretive release by State Health Services and Social Services Departments:

- 1. State CHDP Program Letters and Information Notices - Health Services
- 2. All County Letters - Social Services

- 3. Joint Letters - Health Services and Social Services
- 4. CHDP Program Health Assessment Guidelines - Health Services
- F. Statutes requiring review of new program standards by State Advisory Groups.  
  
New program standards affecting local programs to be reviewed by the California Conference of Local Health Officers.  
  
**Reference:** Health and Safety Code Section 1110.111.
- G. Federal regulations governing States' provision of EPSDT:  
  
**Reference:** Title 42, Code of Federal Regulations (CFR), Section 440.40 and Part 441, Subpart B.
- H. Federal statutes applying to the EPSDT program:  
  
**Reference:** Social Security Act (42 USC Section 139(a) Sections 1902(a) (43), 1905(a)(4)(B), and 1905(r).  
  
**Reference:** OBRA89 - Public Law 101-239, Section 6403.

## **Selected State Laws Relating to the CHDP Program**

The following are selected sections of California laws relating to the CHDP program. These sections have been extracted from California's Health and Safety Code, Insurance Code, and Welfare and Institutions Code. For more current and complete information on State laws, please visit the Legislative Counsel of California's website at [www.leginfo.ca.gov/calaw.html](http://www.leginfo.ca.gov/calaw.html).

This section is not all-inclusive. Not included are other State laws, federal laws, State and federal regulations, or provisions of the CHDP Provider Manual, CHDP Program Guidance Manual, CHDP Program Letters, or CHDP Provider Information Notices.

### **Health and Safety Code Section**

#### **104395. Child Health and Disability Prevention (CHDP) Program Expansion**

The department shall expand the CHDP program contained in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 as follows:

- (a) Any child between birth and 90 days after entrance into first grade, all persons under 21 years of age who are eligible for the California Medical Assistance Program, and any person under 19 years of age whose family income is not more than 200 percent of the federal poverty level shall be eligible for services under the program in the county of which they are a resident. The department shall adopt regulations specifying which age groups shall be given certain types of screening tests and recommendations for referral.
- (b) The first source of referral under the program shall be the child's usual source of health care. If referral is required and no regular source of health care can be identified, the facility or provider providing health screening and evaluation services shall provide a list of three qualified sources of care, without prejudice for or against any specific source.
- (c) The department shall issue protocols for an anti-tobacco education component of the child health and disability prevention medical examination. The protocols shall include the following: dissuading children from beginning to smoke, encouraging smoking cessation, and providing information on the health effects of tobacco use on the user, children, and nonsmokers. The protocols shall also include a focus on health promotion, disease prevention, and risk reduction, utilizing a "wellness" perspective that encourages self-esteem and positive decision making techniques, and referral to an appropriate community smoking cessation program.
- (d) Notwithstanding any other provision of law, the department shall ensure that a portion of the funds in the Child Health Disability Prevention Program budget is used to facilitate the integration of the medical and dental components of all aspects of that program.
- (e) The department shall expand its support and monitoring of county child health and disability prevention program efforts to provide all of the following:

- (1) Review of a representative, statistically valid, randomly selected sample of child health and disability prevention health assessments, including, but not limited to, dental assessments, which result in the discovery of conditions which require follow-up diagnosis and treatment, including but not limited to dental treatment, and which qualify for services under this section. The purpose of the survey and follow-up reviews of local programs is to determine whether necessary diagnosis and treatment services are being provided, and the degree to which those services comply with the intent of the act that added this subdivision. These survey reviews shall include all counties and shall be conducted at least three times a year.
- (2) At least once a year, as part of regular visits to county child and health and disability prevention programs to provide technical assistance, support services and monitoring and evaluation of program performance, department staff shall review the effectiveness of the mandated treatment program. The purpose of this review is to assure that the county is providing appropriate follow-up services for conditions discovered during child health and disability prevention health assessments. This review shall be done in conjunction with the ongoing survey activity of the Child Health and Disability Prevention Branch of the department and shall utilize data resulting from that activity.
- (3) If the department establishes that a county has failed to provide treatment services mandated by the act that added this subdivision, the department shall require the county to submit a plan of correction within 90 days. If the department finds that substantial correction has not occurred within 90 days following receipt of the correction plan, it may require the county to enter into a contract pursuant to Section 16934.5 of the Welfare and Institutions Code for the remainder of the fiscal year and the following fiscal year, and for this purpose shall withhold the same percentage of funds as are withheld from other counties participating in the program pursuant to Section 16934.5 of the Welfare and Institutions Code.

**105300. CHDP program Statutory Relationship to the Childhood Lead Poisoning Prevention Program; Regulatory Authority**

Notwithstanding Section 124130, the department shall have broad regulatory authority to fully implement and effectuate the purposes of this chapter. The authority shall include, but is not limited to, the following:

- (a) The development of protocols to be utilized in screening and the procedures for changing those protocols when more accurate or efficient technologies become available.
- (b) The designation of laboratories which are qualified to analyze whole blood specimens for concentrations of lead and the monitoring of those laboratories for accuracy.
- (c) The development of reporting procedures by laboratories.

- (d) Reimbursement for state-sponsored services related to screening and appropriate case management.
- (e) Establishment of lower concentrations of lead in whole blood than specified by the United States Center for Disease Control for the purpose of determining the existence of lead poisoning.
- (f) Establishment of lower acceptable levels of the concentration of lead in whole blood than those specified by the United States Center for Disease Control for the purpose of determining the need to provide appropriate case management for lead poisoning.
- (g) Development of appropriate case management protocols.
- (h) Notification to the child's parent or guardian of the results of blood lead testing and environmental assessment.
- (i) The establishment of a periodicity schedule for evaluation for childhood lead poisoning.

**105305. Program funding**

The program implemented pursuant to this chapter shall be fully supported from the fees collected pursuant to Section 105310. Notwithstanding the scope of activity mandated by this chapter, in no event shall this chapter be interpreted to require services necessitating expenditures in any fiscal year in excess of the fees, and earnings therefrom, collected pursuant to Section 105310. This chapter shall be implemented only to the extent fee revenues pursuant to Section 105310 are available for expenditure for purposes of this chapter.

**120475. Immunization of children; CHDP program statutory requirement to report to legislature**

On or before March 15, 1991, and on or before March 15 of each year thereafter, the department shall submit a report to the Legislature on all of the following issues:

- (a) The immunization status of young children in the state, based on available data.
- (b) The steps taken to strengthen immunization efforts, particularly efforts through the Child Health and Disability Prevention Program.
- (c) The steps taken to improve immunization levels among currently underserved minority children, young children in family day care and other child care settings, and children with no health insurance coverage.
- (d) The improvements made in ongoing methods of immunization outreach and education in communities where immunization levels are disproportionately low.
- (e) Its recommendations for a comprehensive strategy for fully immunizing all California children and its analysis of the funding necessary to implement the strategy.

**124025. Legislative finding and declaration**

The Legislature finds and declares that many physical and mental disabilities can be prevented, or their impact on an individual lessened, when they are identified and treated before they become chronic and irreversible damage occurs. The Legislature finds and declares that a community-based program of early identification and referral for treatment of potential handicapping conditions will be effective in reducing the incidence of the conditions and will benefit the health and welfare of the citizens of this state.

It is the intent of the Legislature in enacting this article and Section 120475 to establish child health and disability prevention programs, which shall be financed and have standards established at the state level and that shall be operated at the local level, for the purpose of providing early and periodic assessments of the health status of children. It is further intended that child health and disability prevention programs shall make maximum use of existing health care resources and shall utilize, as the first source of screening, the child's usual source of health care so that health screening programs are fully integrated with existing health services, that health care professionals be appropriately represented and utilized in these programs, that outreach programs be developed to stimulate the use of preventive health services, and that services offered pursuant to this article be efficiently provided and be of the highest quality.

**124030. Definitions**

As used in this article and Section 120475:

- (a) "State Board" means the State Maternal, Child, and Adolescent Health Board.
- (b) "Department" means the department.
- (c) "Director" means the director.
- (d) "Governing Body" means the county board of supervisors or boards of supervisors in the case of counties acting jointly.
- (e) "Local Board" means local maternal, child, and adolescent health board.
- (f) "Local health jurisdiction" means county health department or combined health department in the case of counties acting jointly or city health department within the meaning of Section 101185.
- (g) "Child Health and Disability Prevention provider" or "CHDP provider" means any of the following, if approved for participation in the Child Health and Disability Prevention program by the community Child Health and Disability program director in accordance with program standards to practice medicine in California.
  - (1) A physician licensed to practice medicine in California.
  - (2) A family nurse practitioner certified pursuant to Sections 2834 and 2836 of the Business and Professions Code.

- (3) A pediatric nurse practitioner certified pursuant to Sections 2834 and 2836 of the Business and Professions Code.
- (4) A primary care center, clinic, or other public or private agency or organization that provides outpatient health care services.
- (5) A physician's group.
- (6) A licensed clinical laboratory.

**124033.**

- (a) Commencing July 1, 2003, all applications for services under the Child Health and Disability Prevention program shall be filed electronically in accordance with subdivision (b) of Section 14011.7 of the Welfare and Institutions Code.
- (b) To implement the program described in subdivisions (b) to (e), inclusive, of Section 14011.7 of the Welfare and Institutions Code for the use of an electronic application for the Child Health and Disability Prevention program and for preenrollment into the Medi-Cal program or the Healthy Families Program, the following shall apply:
  - (1) The department may contract with public or private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary, only if services provided under the program are specifically identified and reimbursed in a manner that appropriately claims federal financial reimbursement.
  - (2) Contracts, including the Medi-Cal program fiscal intermediary contract for the Child Health and Disability Prevention Program, including any contract amendment, any system change pursuant to a change order, and any project or systems development notice shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Chapter 7 (commencing with Section 11700) of Part 1 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and any policies, procedures, or regulations authorized by these laws.

**124035. Administration; minimum standards for approval; rules and regulations; state plan**

The department shall administer this article and Section 120475 and shall adopt minimum standards for the approval of community child health and disability prevention programs and regulations as necessary. The standards shall allow necessary flexibility in the administration of county programs, taking into account the variability of county needs and resources. However, the standards, rules, and regulations may be adopted only with the advice and written recommendations of the board. Standards shall be adopted for:

- (a) Education and experience requirements for directors of community child health and disability prevention programs.
- (b) Health screening, evaluation, and diagnostic procedures for child health and disability prevention programs.
- (c) Public and private facilities and providers that may participate in community child health and disability prevention programs.

The department shall adopt a five-year state plan for child health and disability prevention services by October 1, 1977. The plan shall include a method for allocating child health and disability prevention funds to counties. The plan shall be reviewed and revised as necessary to provide a basis for allocating state child health and disability prevention program funds throughout the state.

Nothing in this section shall be construed as prohibiting programs provided pursuant to this article from being conducted in public and private school facilities; provided that, with respect to private school facilities, no services provided thereon pursuant to this article and financed by public funds shall result in any material benefit to, or be conducted in a manner that furthers any educational or other mission of, such a school or any person or entity maintaining the school.

**124040. Establishment of programs; plan requirements; standards for procedures; record system**

- (a) The governing body of each county or counties shall establish a community child health and disability prevention program for the purpose of providing early and periodic assessments of the health status of children in the county or counties by July 1, 1974. However, this shall be the responsibility of the department for all counties that contract with the state for health services. Contract counties, at the option of the board of supervisors, may provide services pursuant to this article in the same manner as other county programs, provided the option is exercised prior to the beginning of each fiscal year. Each plan shall include, but is not limited to, the following requirements:
  - (1) Outreach and educational services.
  - (2) Agreements with public and private facilities and practitioners to carry out the programs.
  - (3) Health screening and evaluation services for all children including a physical examination, immunizations appropriate for the child's age and health history, and laboratory procedures appropriate for the child's age and population group performed by, or under the supervision or responsibility of, a physician licensed to practice medicine in California or by a certified family nurse practitioner or a certified pediatric nurse practitioner.
  - (4) Referral for diagnosis or treatment when needed, including, for all children eligible for Medi-Cal, referral for treatment by a provider participating in the Medi-Cal program of the conditions detected, and methods for assuring referral is carried out.

- (5) Record keeping and program evaluations.
- (6) The health screening and evaluation part of each community child health and disability prevention program plan shall include, but is not limited to, the following for each child:
  - 1. A health and developmental history.
  - 2. An assessment of immunization status.
  - 3. An examination for obvious physical defects.
  - 4. Ear, nose, mouth, and throat inspections, including inspection of teeth and gums, and for all children three years of age and older who are eligible for Medi-Cal, referral to a dentist participating in the Medi-Cal program.
  - 5. Screening tests for vision, hearing, anemia, tuberculosis, diabetes, and urinary tract conditions.
- (7) An assessment of nutritional status.
- (8) An assessment of immunization status.
- (9) Where appropriate, testing for sickle cell trait, lead poisoning, and other tests that may be necessary to the identification of children with potential disabilities requiring diagnosis and possibly treatment.
- (10) For all children eligible for Medi-Cal, necessary assistance with scheduling appointments for services and with transportation.
- (b) Dentists receiving referrals of children eligible for Medi-Cal under this section shall employ procedures to advise the child's parent or parents of the need for and scheduling of annual appointments.
- (c) Standards for procedures to carry out health screening and evaluation services and to establish the age at which particular tests should be carried out shall be established by the director. At the discretion of the department, these health screening and evaluation services may be provided at the frequency provider under the Healthy Families Program and permitted in managed care plans providing services under the Medi-Cal program, and shall be contingent upon appropriation in the annual Budget Act. Immunizations may be provided at the frequency recommended by the Committee on Infectious Disease of the American Academy of Pediatrics and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- (d) Each community child health and disability prevention program shall, pursuant to standards set by the director, establish a record system that contains a health case history for each child so that costly and unnecessary repetition of screening, immunization and referral will not occur and appropriate health treatment will be facilitated as specified in Section 124085.

**124045. Services by city; election; powers**

A city that operates an independent health agency may elect to provide the services described in this article with the approval of the department. In this instance, the powers granted a governing body of a county shall be vested in the governing body of the city.

**124050. Directors of community programs**

Each community child health and disability program shall have a director meeting qualification standards by the department, appointed by the governing body, except for counties contracting with the state for health services.

**124055. Intercounty service contracts**

Any community child health and disability prevention program may contract to furnish services to any other county if the contract is approved by the director.

**124060. Budget update; community child health and disability prevention plan; requirements; multi-year base plan**

- (a) On or before September 15 of each year, each county program director shall submit a budget update for the subsequent fiscal year that provides the following information:
  - (1) A summary of the previous year's activity, including the number of children screened, the number of children referred for diagnosis and treatment, by condition, and the cost of screening services.
  - (2) A summary description of the results of cases in that a treatable disability was identified and referral made.
  - (3) A projection and cost estimates of the number of children to be screened for the fiscal year for which the budget is being submitted.
- (b) The multi-year base community child health and disability prevention plan shall include the following:
  - (1) An assessment of the adequacy and availability of the facilities and providers to provide health screening diagnostic and treatment services.
  - (2) A description of the child health and disability prevention program to be offered, including expected participating providers and outreach mechanisms to be utilized.
  - (3) A summary description of the current year's activity, including the number of children screened, the number of children referred for diagnosis and treatment, by condition, and the cost of screening services.
  - (4) A description of how existing school health resources, including school health personnel, are to be utilized for outreach and other services.
  - (5) Budget estimates, including all sources of revenue, for the budget.

- (c) On or before September 15 of each year each governing board shall submit an update to the multi-year base community child health and disability prevention plan.

The director shall determine the amount of state funds available for each county for specified services under an approved multi-year base community child health and disability prevention plan, as updated, from state funds appropriated for child health and disability prevention services.

If the amount appropriated in the Budget Act for the fiscal year as enacted into law differs from the amount in the budget submitted by the Governor for the fiscal year, each governing board shall submit an additional revised update in the form and at the time specified by the department.

Notwithstanding any other provision of this article, no new community child health and disability prevention plan shall be submitted by a county until September 15, 1983. Each county plan and budget approved for the 1981-82 fiscal year shall be updated on or before September 15 by the governing body of each county for the 1982-83 and 1983-84 fiscal years pursuant to regulations adopted by the department. On or before September 15, 1983, the governing body of each county shall prepare and submit to the department a multi-year base plan and budget for the 1984-85 fiscal year that shall be annually updated on or before September 15 of each subsequent year pursuant to regulations adopted by the department.

The department shall develop and implement the format and procedures for the preparation and submission of a multi-year base plan update in order for the counties to have sufficient time prior to September 15, 1983, to prepare and submit their multi-year base plan by September 15, 1983.

For the purposes of simplifying and reducing plan requirements, the Legislature intends that the annual update shall not duplicate any of the material in the multi-year base plan, but serve as a progress report both evaluating what has been accomplished over the past year and describing in more detail what will be accomplished in relation to each of the elements in the base plan during the coming year.

**124065. State reimbursement**

Counties shall be reimbursed for the amount required by the county to carry out its community child health and disability prevention program in accordance with the approved community child health and disability prevention plan. Claims for state reimbursement shall be made in the manner as the director shall provide. Each claim for state reimbursement shall be payable from the appropriation made for the fiscal year when the expenses upon which the claim is based are incurred.

There shall be no reimbursement for expenditures for the treatment of disabilities identified as a result of the program or for capital improvements or the purchase or construction of buildings, except for the equipment items and remodeling expenses as may be allowed by regulations adopted by the director.

**124070. State reimbursement**

Counties shall be reimbursed for the amount required by the county to carry out its community child health and disability prevention program in accordance with the approved community child health and disability prevention plan. Claims for state reimbursement shall be made in a manner as the director shall provide. Each claim for state reimbursement shall be payable from the appropriation made for the fiscal year in which the expenses upon which the claim is based are incurred.

There shall be no reimbursement for expenditures for the treatment of disabilities identified as a result to the program, except for the costs of immunizations necessary to bring the child current in his or her immunization status as provided for by regulations of the department, or for capital improvements or the purchase or construction of buildings, except for the equipment items and remodeling expenses as may be allowed by regulations adopted by the director.

**124075. Schedule and method of reimbursement; use of federal funds**

- (a) In order to ensure the maximum utilization of the California Medical Assistance Program and other potential reimbursement sources, the department shall develop a schedule and method of reimbursement at reasonable rates for services rendered pursuant to this article. The reimbursement schedule shall include provision for well child examinations as well as for administrative expenses incurred by providers pursuant to meeting this article. Inquiry shall be made of all recipients of services under this article as to their entitlement for third-party reimbursement for medical services. Where an entitlement exists it shall be billed. Notwithstanding subdivision (c) of Section 14000 of the Welfare and Institutions Code and Section 14005 of that code, the California Medical Assistance Program shall be billed for services rendered pursuant to this article for every Medi-Cal eligible beneficiary.
- (b) The department and counties shall maximize the use of federal funds for carrying out of this article, including using state or county funds to match funds claimable under Title 19 of the Social Security Act. Services and administrative support costs claimable under federal law shall include, but not be limited to, outreach, health education, case management, resource development, and training at state and local levels. Any federal funds received shall augment and not replace funds appropriated from the General Fund for carrying out the purposes of this chapter.

**124080. Contracts for claims processing**

The department may contract with a private entity for the performance of processing claims for state reimbursement, so long as the cost of the contract is no more than 85 percent of the cost of the service if performed in state service and there is compliance with other applicable provisions of the Government Code including, but not limited to, Sections 19130 to 19132, inclusive.

**124085. Certificate of receipt; health screening and evaluation services; waiver by parent or guardian**

On and after July 1, 1976, each child eligible for services under this article shall, within 90 days after entrance into the first grade, provide a certificate approved by the department to the school where the child is to enroll documenting that within the prior 18 months the child has received the appropriate health screening and evaluation services specified in Section 124040. A waiver

signed by the child's parents or guardian indicating that they do not want or are unable to obtain the health screening and evaluation services for their children shall be accepted by the school in lieu of the certificate. If the waiver indicates that the parent or guardian was unable to obtain the services for the child, then the reasons why should be included in the waiver.

**124090. Eligibility for services; rules and regulations specifying age groups for screening tests and recommendations for referral; sources of referral**

Any child between birth and 90 days after entrance into the first grade and all persons under 21 years of age who are eligible for the California Medical Assistance Program shall be eligible for services from the child health and disabilities prevention program in the county where they are a resident. The department, with review and recommendation by the board, shall adopt regulations specifying age groups that shall be given certain types of screening tests and recommendations for referral.

The first source of referral shall be the child's usual source of health care. If referral is required and no regular source of health care can be identified, the facility or provider providing health screening and evaluation services shall provide a list of three qualified sources of care, without prejudice for or against any specific source.

**124095. Copy of results of screening and evaluation; reference for further diagnosis and treatment**

Each community child health and disability prevention program shall provide the child or his or her parent or guardian with a copy of the results of the health screening and evaluation, as well as an explanation of the meaning of the results, and shall, where the need indicates, refer the child for further diagnosis and treatment.

**124100. School districts and private schools; information to parents or guardians of kindergarten children; withholding of average daily-attendance funds**

- (a) In cooperation with the county child health and disability prevention program, the governing body of every school district or private school that has children enrolled in kindergarten shall provide information to the parents or guardians of all children enrolled in kindergarten of this article and Section 120475. Every school district or private school that has children enrolled in the first grade shall report by January 15 of each year to the county child health and disability prevention program, the department, and the Department of Education the following information:
  - (1) The total number of children enrolled in first grade.
  - (2) The number of children who have had a health screening examination, as evidenced by the certificate required by Section 124085.
  - (3) The number of children whose parents or guardian have given written waiver pursuant to Section 124085 that they do not want their child to receive a health screening examination.
- (b) Each county child health and disability prevention program shall reimburse school districts for information provided pursuant to this section. The

Superintendent of Public Instruction may withhold state average daily attendance funds to any school district for any child for whom a certification or parental waiver is not obtained.

**124105. Health screening; school districts; exclusion of enrolled pupils from school; short title; legislative intent**

- (a) This section shall be known and may be cited as the "Hughes Children's Health Enforcement Act."
- (b) The Legislature recognizes the importance of health to learning and to a successful academic career. The Legislature also recognizes the important role of schools in ensuring the health of pupils through health education and the maintenance of minimal health standards among the pupil population. Therefore, it is the intent of the Legislature that schools ensure that pupils receive a health screening before the end of the first grade.
- (c) The department shall compile district information, using the information reported pursuant to Section 124100, and report to the Legislature the percentage levels of compliance with Section 124085 on an annual basis commencing January 1, 1994, utilizing data from the prior school year.
- (d) The governing board of each school district shall exclude from school, for not more than five days, any first grade pupil who has not provided either a certificate or a waiver, as specified in Section 124085, on or before the 90th day after the pupil's entrance into the first grade. The exclusion shall commence with the 91st calendar day after the pupil's entrance into the first grade, unless school is not in session that day, then the exclusion shall commence on the next succeeding school day. A child shall not be excluded under this section if the pupil's parent or guardian provides to the district either a certificate or a waiver as specified in Section 124085.
- (e) The governing board of a school district may exempt any pupil from the exclusion described in subdivision (d) if, at least twice between the first day and the 90th day after the pupil's entrance into the first grade, the district has contacted the pupil's parent or guardian and the parent or guardian refuses to provide either a certificate or a waiver as specified in Section 124085. The number of exemptions from exclusion granted by a school district pursuant to this subdivision may not exceed 5 percent of a school district's first grade enrollment. It is the intent of the Legislature that exemptions from exclusion are used in extraordinary circumstances, including, but not limited to, family situations of great dysfunction or disruption, such as substance abuse by parents or guardians, child abuse, or child neglect.
- (f) It is the intent of the Legislature that, upon a pupil's enrollment in kindergarten or first grade, the governing board of the school district notify the pupil's parent or guardian of the obligation to comply with Section 124085 and the availability for low-income children of free health screening for up to 18 months prior to entry into first grade through the Child Health Disabilities Prevention Program.

- (g) It is the intent of the Legislature that school districts provide information to parents regarding the requirements of Section 124085 within the notification of immunization requirements. Moreover, the Legislature intends that the information sent to parents encourage parents to obtain health screens simultaneously with immunizations.

**124110. Confidentiality of information and results; health screening and evaluation; release; professional interpretation of results**

All information and results of the health screening and evaluation of each child shall be confidential and shall not be released without the informed consent of a parent or guardian of the child.

The results of the health screening and evaluation shall not be released to any public or private agency, even with the consent of a parent or guardian unless accompanied by a professional interpretation of what the results mean.

**Insurance Code (Re: CHDP Gateway)**

**12693.41.**

- (a) The board shall consult and coordinate with the State Department of Health Services in implementing a preenrollment program into the Healthy Families Program or the Medi-Cal program pursuant to subdivision (b) of Section 14011.7 of the Welfare and Institutions Code. The board shall accept the follow-up application provided for in Section 14011.7 of the Welfare and Institutions Code as an application for the Healthy Families Program. Preenrollment shall be administered by the State Department of Health Services to provide full-scope benefits pursuant to Medi-Cal program requirements, at no cost to the applicant.
- (b) The board may use the state fiscal intermediary for Medicaid to process the eligibility determinations and payments required pursuant to Section 14011.7 of the Welfare and Institutions Code.
- (c) The board shall be exempt from the requirements of Chapter 7 (commencing with Section 11700) of Division 3 of Title 2 of the Government Code and Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code as those requirements apply to the use of processing services by the state fiscal intermediary.

The board may adopt emergency regulations to implement preenrollment into the Healthy Families Program or the Medi-Cal program pursuant to Section 14011.7 of the Welfare and Institutions Code. The emergency regulations shall include, but not be limited to, regulations that implement any changes in rules relating to eligibility, enrollment, and disenrollment in the programs pursuant to Sections 12693.45 and 12693.70. The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, and general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and one readoption of those regulations

authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations and each shall remain in effect for no more than 180 days.

This section shall become operative on April 1, 2003.

### **Welfare and Institutions Code (Re: CHDP Gateway)**

#### **14011.7.**

- (a) To the extent allowed under federal law and only if federal financial participation is available, the department shall exercise the option provided in Section 1396r-1a of Title 42 of the United States Code and the Managed Risk Medical Insurance Board shall exercise the option provided in Section 1397gg(e)(1)(D) of Title 42 of the United States Code to implement a program for preenrollment of children into the Medi-Cal program or the Healthy Families Program. Upon the exercise of both of the federal options described in this subdivision, the department shall implement and administer a program of preenrollment of children into the Medi-Cal program or the Healthy Families Program.
- (b) Before July 1, 2003, the department shall develop an electronic application to serve as the application for preenrollment into the Medi-Cal program or the Healthy Families Program and to also serve as an application for the Child Health and Disability Prevention (CHDP) program, to the extent allowed under federal law.
- (c)
  - (1) The department may designate, as necessary, those CHDP program providers described in paragraphs (1) to (5), inclusive, of subdivision (g) of Section 124030 of the Health and Safety Code as qualified entities who are authorized to determine eligibility for the CHDP program and for preenrollment into either the Medi-Cal program or the Healthy Families Program as authorized under this section.
  - (2) The CHDP provider shall assist the parent or guardian of the child seeking eligibility for the CHDP program and for preenrollment into the Medi-Cal program or the Healthy Families Program in completing the electronic application.
- (d) The electronic application developed pursuant to subdivision (b) may only be filed through the CHDP program when the child is in need of CHDP program services in accordance with the periodicity schedule used by the CHDP program.
- (e)
  - (1) The electronic application developed pursuant to subdivision (b) shall request all information necessary for a CHDP provider to make an immediate determination as to whether a child meets the eligibility requirements for CHDP and for preenrollment into either the Medi-Cal program or the Healthy Families Program pursuant to the federal options

described in Section 1396r-1a or 1397gg(e)(1)(D) of Title 42 of the United States Code.

- (2)
  - (A) If the electronic application indicates that the child is seeking eligibility for either no cost full-scope Medi-Cal benefits or enrollment in the Healthy Families Program, the department shall mail to the child's parent or guardian a follow-up application for Medi-Cal program eligibility or enrollment in the Healthy Families Program. The parent or guardian of the child shall be advised to complete and submit to the appropriate entity the follow-up application.
  - (B) The follow-up application, at a minimum, shall include all notices and forms necessary for both a Medi-Cal program and a Healthy Families Program eligibility determination under state and federal law, including, but not limited to, any information and documentation that is required for the joint application package described in Section 14011.1.
  - (C) The date of application for the Medi-Cal program or the Healthy Families Program is the date the completed follow-up application is submitted with the appropriate entity by the parent or guardian.
- (3) Upon making a determination pursuant to paragraph (1) that a child is eligible, the CHDP provider shall inform the child's parent or guardian of both of the following:
  - (A) That the child has been determined to be eligible for services under the CHDP program and, if applicable, eligible for preenrollment into either the Medi-Cal program or the Healthy Families Program.
  - (B) That if the child has been determined to be eligible for preenrollment into either the Medi-Cal program or the Healthy Families Program, the period of preenrollment eligibility will end on the last day of the month following the month in which the determination of preenrollment eligibility is made, unless the parent or guardian completes and returns to the appropriate entity the follow-up application described in paragraph (2) on or before that date.
- (4) If the follow-up application described in paragraph (2) is submitted on or before the last day of the month following the month in which a determination is made that the child is eligible for preenrollment into either the Medi-Cal program or the Healthy Families Program, the period of preenrollment eligibility shall continue until the completion of the determination process for the applicable program or programs.
- (f) The scope and delivery of benefits provided to a child who is preenrolled for the Healthy Families Program pursuant to this section shall be identical to the scope and delivery of benefits received by a child who is preenrolled for the Medi-Cal program pursuant to this section.

- (g) The department and the Managed Risk Medical Insurance Board shall seek approval of any amendments to the state plan, necessary to implement this section, for purposes of funding under Title XIX (42 USC 1396 et seq.) and Title XXI (42 USC 1397aa et seq.) of the Social Security Act. Notwithstanding any other provision of law and only when all necessary federal approvals have been obtained, this section shall be implemented only to the extent federal financial participation is available.
- (h) Upon the implementation of this section, this section shall control in the event of a conflict with any provision of Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code governing the Child Health and Disability Prevention Program.
- (i) To implement this section, the department may contract with public or private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary, only if services provided under the program are specifically identified and reimbursed in a manner that appropriately claims federal financial reimbursement. Contracts, including the Medi-Cal fiscal intermediary contract for the Child Health and Disability Prevention Program, including any contract amendment, any system change pursuant to a change order, and any project or systems development notice shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Chapter 7 (commencing with Section 11700) of Part 1 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and any policies, procedures, or regulations authorized by these laws.
- (j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all-county letters or similar instructions, without taking any further regulatory action. Thereafter, the department shall adopt regulations, as necessary, to implement this section in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.
- (k) Notwithstanding subdivision (g), in no event shall this section be implemented before April 1, 2003.

### **Legislation, Regulations, and Guidelines for the HCPCFC**

- A. Enabling legislation of the HCPCFC.

**Reference:** Welfare and Institutions Code; Section 16501.3.

- B. Medi-Cal regulations pertaining to the availability and reimbursement of EPSDT services through the CHDP program.

**Reference:** CCR, Title 22, Sections 51340 and 51532.

- C. Statutes and regulations defining county Social Services Department responsibilities for meeting HCPCFC requirements.

1. Social Services Statutes

**Reference:** Welfare and Institutions Code Section 16010, 358.1, 361.5, 366.1, 366.22(b) or 366.22(d).

2. Social Services Regulations

**Reference:** Child Welfare Services Program Standards: MPP Sections 31-002(10), 31-075 (l 1-2), 31-205 (h), 31-206.35, 31-206.351, 31-206.352, 31-206.36, 31-206.361, 31-206.362, 31-335 .1, 31-401.4, 31-401.41, 31-401.412, 31-401.413, 31-405.1(j), 31-405.1(k, l, l1), and 31-420.1(.7).

3. Medi-Cal Regulations

**Reference:** CCR, Title 22, Sections 50031; 50157(a), (d), (e), and (f) and 50184(b).

- D. Current interpretive releases by California Departments of Health Services and Social Services.

1. State CHDP Program Letters and Information Notices - Health Services. Specifically CHDP Program Letter 99-6 and CMS Information Notice 99-E.
2. All County Letters - Social Services. Specifically, All County Information Notice No I-55-99 and All County Letter No. 99-108.
3. Joint Letters - Health Services and Social Services
4. CHDP Program Health Assessment Guidelines - Health Services

- E. New program standards affecting local programs to be reviewed by the California Conference of Local Health Officers.

**Reference:** Health and Safety Code, Section 100925

- F. New regulations shall be adopted only after consultation and approval by the California Conference of Local Health Officers.

**Reference:** Health and Safety Code, Section 100950.

- G. Federal regulations governing States' provision of EPSDT:

**Reference:** Title 42, Code of Federal Regulations (CFR), Section 440.40 and Part 441, Subpart B.

- H. Federal statutes applying to the EPSDT program:

**Reference:** Social Security Act (42 USC Section 139(a) Sections 1902(a) (43), 1905(a)(4)(B), and 1905(r).

**Reference:** OBRA89 - Public Law 101-239, Section 6403.

## **Selected State Laws Relating to the HCPCFC**

The following are selected sections of California laws relating to the HCPCFC. These sections have been extracted from California's Welfare and Institutions Code. For more current and complete information on State laws, please visit the Legislative Counsel of California's website at [www.leginfo.ca.gov/calaw.html](http://www.leginfo.ca.gov/calaw.html).

This section is not all-inclusive. Not included are other State laws, federal laws, State and federal regulations, or provisions of the CHDP Provider Manual, CHDP Program Guidance Manual, CHDP Program Letters, or CHDP Provider Information Notices.

### **Welfare and Institutions Code Section**

#### **16501.**

- (a) As used in this chapter, "child welfare services" means public social services which are directed toward the accomplishment of any or all the following purposes: protecting and promoting the welfare of all children, including handicapped, homeless, dependent, or neglected children; preventing or remedying, or assisting in the solution of problems which may result in, the neglect, abuse, exploitation, or delinquency of children; preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing breakup of the family where the prevention of child removal is desirable and possible; restoring to their families children who have been removed, by the provision of services to the child and the families; identifying children to be placed in suitable adoptive homes, in cases where restoration to the biological family is not possible or appropriate; and assuring adequate care of children away from their homes, in cases where the child cannot be returned home or cannot be placed for adoption. "Child welfare services" also means services provided on behalf of children alleged to be the victims of child abuse, neglect, or exploitation. The child welfare services provided on behalf of each child represent a continuum of services, including emergency response services, family preservation services, family maintenance services, family reunification services, and permanent placement services. The individual child's case plan is the guiding principle in the provision of these services. The case plan shall be developed within 30 days of the initial removal of the child or of the in-person response required under subdivision (f) of Section 16501 if the child has not been removed from his or her home, or by the date of the jurisdictional hearing pursuant to Section 356, whichever comes first.
- (1) Child welfare services may include, but are not limited to, a range of service-funded activities, including case management, counseling, emergency shelter care, emergency in-home caretakers, temporary in-home caretakers, respite care, therapeutic day services, teaching and demonstrating homemakers, parenting training, substance abuse testing, and transportation. These service-funded activities shall be available to children and their families in all phases of the child welfare program in accordance with the child's case plan and departmental regulations.

Funding for services is limited to the amount appropriated in the annual Budget Act and other available county funds.

- (2) Service-funded activities to be provided may be determined by each county, based upon individual child and family needs as reflected in the service plan.
- (3) As used in this chapter, "emergency shelter care" means emergency shelter provided to children who have been removed pursuant to Section 300 from their parent or parents or their guardian or guardians. The department may establish, by regulation, the time periods for which emergency shelter care shall be funded. For the purposes of this paragraph, "emergency shelter care" may include "transitional shelter care facilities" as defined in paragraph (11) of subdivision
  - (a) of Section 1502 of the Health and Safety Code.
  - (b) As used in this chapter, "respite care" means temporary care for periods not to exceed 72 hours. This care may be provided to the child's parents or guardians. This care shall not be limited by regulation to care over 24 hours. These services shall not be provided for the purpose of routine, ongoing child care.
  - (c) The county shall provide child welfare services as needed pursuant to an approved service plan and in accordance with regulations promulgated, in consultation with the counties, by the department. Counties may contract for service-funded activities as defined in paragraph (1) of subdivision (a). Each county shall use available private child welfare resources prior to developing new county-operated resources when the private child welfare resources are of at least equal quality and lesser or equal cost as compared with county-operated resources. Counties shall not contract for needs assessment, client eligibility determination, or any other activity as specified by regulations of the State Department of Social Services, except as specifically authorized in Section 16100.
  - (d) Nothing in this chapter shall be construed to affect duties which are delegated to probation officers pursuant to Sections 601 and 654.
  - (e) Any county may utilize volunteer individuals to supplement professional child welfare services by providing ancillary support services in accordance with regulations adopted by the State Department of Social Services.
  - (f) As used in this chapter, emergency response services consist of a response system providing in-person response, 24 hours a day, seven days a week, to reports of abuse, neglect, or exploitation, as required by Article 2.5 (commencing with Section 11164) of Chapter 2 of Title 1 of Part 4 of the Penal Code for the purpose of

investigation pursuant to Section 11166 of the Penal Code and to determine the necessity for providing initial intake services and crisis intervention to maintain the child safely in his or her own home or to protect the safety of the child. County welfare departments shall respond to any report of imminent danger to a child immediately and all other reports within 10 calendar days. An in-person response is not required when the county welfare department, based upon an evaluation of risk, determines that an in-person response is not appropriate. This evaluation includes collateral, contacts, a review of previous referrals, and other relevant information, as indicated.

- (g) As used in this chapter, family maintenance services are activities designed to provide in-home protective services to prevent or remedy neglect, abuse, or exploitation, for the purposes of preventing separation of children from their families.
- (h) As used in this chapter, family reunification services are activities designed to provide time-limited foster care services to prevent or remedy neglect, abuse, or exploitation, when the child cannot safely remain at home, and needs temporary foster care, while services are provided to reunite the family.
- (i) As used in this chapter, permanent placement services are activities designed to provide an alternate permanent family structure for children who because of abuse, neglect, or exploitation cannot safely remain at home and who are unlikely to ever return home. These services shall be provided on behalf of children for whom there has been a judicial determination of a permanent plan for adoption, legal guardianship, or long-term foster care.
- (j) As used in this chapter, family preservation services include those services specified in Section 16500.5 to avoid or limit out-of-home placement of children, and may include those services specified in that section to place children in the least restrictive environment possible.
- (k)
  - (1)
    - (A) In any county electing to implement this subdivision, all county welfare department employees who have frequent and routine contact with children shall, by February 1, 1997, and all welfare department employees who are expected to have frequent and routine contact with children and who are hired on or after January 1, 1996, and all such employees whose duties change after January 1, 1996, to include frequent and routine

contact with children, shall, if the employees provide services to children who are alleged victims of abuse, neglect, or exploitation, sign a declaration under penalty of perjury regarding any prior criminal conviction, and shall provide a set of fingerprints to the county welfare director.

- (B) The county welfare director shall secure from the Department of Justice a criminal record to determine whether the employee has ever been convicted of a crime other than a minor traffic violation. The Department of Justice shall deliver the criminal record to the county welfare director.
- (C) If it is found that the employee has been convicted of a crime, other than a minor traffic violation, the county welfare director shall determine whether there is substantial and convincing evidence to support a reasonable belief that the employee is of good character so as to justify frequent and routine contact with children.
- (D) No exemption shall be granted pursuant to subparagraph (C) if the person has been convicted of a sex offense against a minor, or has been convicted of an offense specified in Section 220, 243.4, 264.1, 273d, 288, or 289 of the Penal Code, or in paragraph (1) of Section 273a of, or subdivision (a) or (b) of Section 368 of, the Penal Code, or has been convicted of an offense specified in subdivision (c) of Section 667.5 of the Penal Code. The county welfare director shall suspend such a person from any duties involving frequent and routine contact with children.
- (E) Notwithstanding subparagraph (D), the county welfare director may grant an exemption if the employee or prospective employee, who was convicted of a crime against an individual specified in paragraph (1) or (7) of subdivision (c) of Section 667.5 of the Penal Code, has been rehabilitated as provided in Section 4852.03 of the Penal Code and has maintained the conduct required in Section 4852.05 of the Penal Code for at least 10 years and has the recommendation of the district attorney representing the employee's or prospective employee's county of residence, or if the employee or prospective employee has received a certificate of rehabilitation pursuant to Chapter 3.5 (commencing with Section 4852.01) of Title 6 of Part 3 of the Penal Code. In that case, the county

welfare director may give the employee or prospective employee an opportunity to explain the conviction and shall consider that explanation in the evaluation of the criminal conviction record. If no criminal record information has been recorded, the county welfare director shall cause a statement of that fact to be included in that person's personnel file. (2) For purposes of this subdivision, a conviction means a plea or verdict of guilty or a conviction following a plea of no lo contendere. Any action which the county welfare director is permitted to take following the establishment of a conviction may betaken when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence, notwithstanding a subsequent order pursuant to Sections 1203.4 and 1203.4a of the Penal Code permitting the person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment. For purposes of this subdivision, the record of a conviction, or a copy thereof certified by the clerk of the court or by a judge of the court in which the conviction occurred, shall be conclusive evidence of the conviction.

**16501.3.**

- (a) The Department of Social Services shall establish a program of public health nursing in the child welfare services program. The purpose of the public health nursing program shall be to enhance the physical, mental, dental, and developmental well being of children in the child welfare system.
- (b) As a condition of receiving funds under this section, counties shall use the services of a foster care public health nurse. The foster care public health nurse shall work with the appropriate child welfare services workers to coordinate health care services and serve as a liaison with health care professionals and other providers of health-related services. This shall include coordination with county mental health plans and local health jurisdictions, as appropriate.
- (c) The duties of a foster care public health nurse may include, but need not be limited to, the following:
  - (1) Collecting health information and other relevant data on each foster child as available, receiving all collected information to determine appropriate referral and services, and expediting referrals to providers in the community for early intervention services, specialty services, dental care, mental health services, and other health-related services required by the child.

- (2) Participating in medical care planning and coordinating for the child. This may include, but is not limited to, assisting caseworkers in arranging for comprehensive health and mental health assessments, interpreting the results of health assessments or evaluations for the purpose of case planning and coordination, facilitating the acquisition of any necessary court authorizations for procedures or medications, advocating for the health care needs of the child and ensuring the creation of linkage among various providers of care.
  - (3) Providing follow-up contact to assess the child's progress in meeting treatment goals.
- (d) The services provided by foster care public health nurses under this section shall be limited to those for which reimbursement may be claimed under Title XIX at an enhanced rate for services delivered by skilled professional medical personnel. Notwithstanding any other provision of law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation, as provided under Title XIX of the federal Social Security Act (42 USC Sec. 1396 et seq.), is available.

Notwithstanding Section 10101 of the Welfare and Institutions Code, there shall be no required county match of the nonfederal cost of this program.

## Annual Review for Cash Aid and Food Stamps (TEMP CA 600)

Online Version: [www.dss.cahwnet.gov/pdf/TEMPCA600.pdf](http://www.dss.cahwnet.gov/pdf/TEMPCA600.pdf)

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

### ANNUAL REVIEW FOR CASH AID AND FOOD STAMPS

A redetermination of your continued eligibility for cash aid and/or recertification for food stamps is now due. You do not need to come to the office for an interview unless you want to.

If you get food stamps, your certification period ends on the last day of next month. If you want to keep getting food stamps, you must fill out the TEMP DFA 377.2B ESP, Shelter Information, and return it with your next Monthly Report.

The TEMP DFA 377.2B ESP, Shelter Information:

- ☐ is enclosed
- ☐ will be mailed under separate cover with the Notice of Expiration of Certification, TEMP DFA 377.2A ESP

You need to read and save the enclosed important informing documents. They give you facts about cash aid, food stamps, the Cash Aid Lump Sum Rule, Greater Avenues to Independence (GAIN), Food Stamp Employment and Training Rules, the Child Health and Prevention Disability Prevention Program, Family Planning Services, etc.

If you have any questions or want an interview, call your worker.

Please submit the following items:

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TEMP CA 600 (4/99) ESP COVERLETTER - RECOMMENDED FORM



**CHDP Referral (PM 357)**

State of California—Health and Human Services Agency

Department of Health Services

**CHDP REFERRAL**

All Medi-Cal eligible persons under 21 years of age can receive a health and dental check-up.

Client: Fill in unshaded areas only.

**PART A: Completed by county Department of Social Services (DSS)/welfare staff for all cases requesting services or additional information**

1. Case name (last)	(first)	(middle)	2. County code	3. Aid code	4. Case number
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5. ☐ Requested additional information, but no services.**Requested Medical Services (Health Assessment)****Requested Dental Services**

6. Services <input type="checkbox"/> Yes <input type="checkbox"/> No	7. Transportation <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Scheduling <input type="checkbox"/> Yes <input type="checkbox"/> No	9. Services <input type="checkbox"/> Yes <input type="checkbox"/> No	10. Transportation <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Scheduling <input type="checkbox"/> Yes <input type="checkbox"/> No
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12. ☐ New application13. ☐ Redetermination14. ☐ Self-referral15. ☐ CALWORKS16. ☐ Foster care17. ☐ Medi-Cal only18. ☐ Share-of-cost

19. Primary language, if other than English \_\_\_\_\_

20. Other circumstances \_\_\_\_\_

Person Number	Client(s) Name (Last, First, Middle)	Birth Date			Age	If health care plan member, give plan name
		Month	Day	Year		
21.	Parent or caretaker name					
22.	Other parent in home					
23.	Child's name					
24.	Child's name					
25.	Child's name					
26.	Child's name					
27.	Child's name					
28.	Other person in home					

29. Residence address (number, street)	City	State	ZIP code	32. Home phone
		CA		( )
31. Mailing address (if different) (number, street, P.O. Box)	City	State	ZIP code	32. Message phone
				( )

33. Family or child's doctor (optional)

34. Family or child's dentist (optional)

This information is requested to meet federal requirements (Federal Register CFR 42, Part 441) and to inform you of services available. The county is required by law to keep this information confidential except as provided in state or federal law or regulation. Further information is available at your local welfare or CHDP offices.

Comments:

35. DSS worker signature	36. DSS worker number	37. DSS worker telephone	38. Date eligibility determined
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Copy 1—County CHDP

Copy 2—County CHDP

Copy 3—Client Case Report (Welfare Department)  
CHDP Referral and Case Management Form

12-1204.34

PM 357 (6/99) Required Form

State of California—Health and Human Services Agency

Department of Health Services

**PART B: Completed by EPSDT staff to document assistance with requested health assessment and/or dental services.**

Case name (last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_

Contact attempt with responsible person:

Type of Contact	Date	Result	Who Contacted	Date	Result	Who Contacted	FINAL RESULT:  <input type="checkbox"/> Contact made <input type="checkbox"/> No contact made
<input type="checkbox"/> Face-to-face							
<input type="checkbox"/> Telephone							
<input type="checkbox"/> Mail							

Comments:

Client Name	Type T S	Assistance Given	Date	Provider Name and Telephone	Appt. Date	Appt. Kept		Further Dx/ Rx Needed		Source of Info.	Date PM 160 Received
						Yes	No	Yes	No		
	M										
	D										
	M										
	D										
	M										
	D										
	M										
	D										

(If more space is needed, attach additional sheets.)

Comments:

EPSDT worker signature _____	Date _____
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**Part C: Completed by CHDP program staff to document follow-up to diagnosis and treatment.**

Contact attempt with responsible person:

Type of Contact	Date	Result	Who Contacted	Date	Result	Who Contacted	FINAL RESULT:  <input type="checkbox"/> Contact made <input type="checkbox"/> No contact made
<input type="checkbox"/> Face-to-face							
<input type="checkbox"/> Telephone							
<input type="checkbox"/> Mail							

Comments:

Client Name	Type of Condition	Response to Offer		Assistance Given	Date	Provider Name and Telephone	Appt. Date	Appt. Kept		Source of Info.
		Trans.	Sched.					Yes	No	

Comments:

CHDP Health Professional Signature _____	Date _____
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**INSTRUCTIONS FOR COMPLETING PART A**

**ITEM**

- 1-4 Self-explanatory.
  - 5 Check the box if no services are requested but the client wants additional information about the program.
  - 6 Check yes or no as appropriate.
  - 7-8 If item 6 is checked no, skip these items. If item 6 is checked yes, check the boxes in both items 7 and 8 indicating the response to the offer of transportation and scheduling assistance.
  - 9 Check yes or no as appropriate.
  - 10-11 If item 9 is checked no, skip these items. If item 9 is checked yes, check the boxes in both items 10 and 11 indicating the response to the offer of transportation and scheduling assistance.
  - 12-13 When the referral is being made by a CalWORKS, Medi-Cal, or placement worker, check item 12 if the request for services is from a new application or restoration or item 13 if the request is made at the annual redetermination.
  - 14 When services have been requested directly from the local EPSDT Unit or CHDP Program, check item 14.
  - 15-17 Check the one applicable box.
  - 18 Check the box when a Medi-Cal only beneficiary has to pay a share of the costs.
  - 19-20 Complete if applicable. Indicate special communications needs such as deaf, blind, or illiterate—for other circumstances, item 20.
  - 21-28 Fill in the state person number. (Example: 01-father, 02-mother, 11-child, etc.), and the name of the health care plan, if applicable. A person number need not be entered on self-referrals. The unshaded portion must be completed in full by the county welfare department, local EPSDT Unit, or CHDP Program staff for self-referrals, or may be completed by the client.
  - 29-32 Record the caretaker's address and telephone number.
  - 33-34 Optional—not required. Enter the name of the doctor or dentist who currently provides care the eligible children.
- Comments: Use this section to record any comments which will help recipients receive requested services, such as the best time for them to be contacted.
- 35-37 Self-explanatory.
  - 38 "Date eligibility determined"—Enter the date the application is determined eligible, not the date the application was made. For redetermination, the date eligibility determined is the date that the county verifies and certifies that eligibility continues. For "self-referrals" the date of request for services should be entered.

12.1204.35.a

## CHDP Referral for SAWS Automated Template

<b>SOME COUNTY DEPARTMENT OF SOCIAL SERVICES</b> 760 Madison Avenue P.O. Box 4650 Anywhere, CA 95973						
<b>SAWS CHDP REFERRAL</b>						
<b>CASE INFORMATION</b>						Date:
CASE LAST NAME	FIRST	M	APP	CO	AID CODE	CASE NUMBER
				29	84	
RESIDENCE ADDRESS				HOME TELEPHONE:		
MAILING ADDRESS:				MESSAGE PHONE:		
CASE STATUS		PRIMARY LANGUAGE				
DATE ELIGIBILITY DETERMINED:						
<input type="checkbox"/> NEW APPLICATION <input type="checkbox"/> REDETERMINATION <input type="checkbox"/> SELF-REFERRAL						
<input type="checkbox"/> CALWORKS <input type="checkbox"/> FOSTER CARE <input type="checkbox"/> MEDI-CAL ONLY <input type="checkbox"/> SHARE OF COST						
OTHER CIRCUMSTANCES: _____						
<b>PARENT/CARETAKER</b>						
PERS LAST NAME	FIRST	M	BIRTH	AGE	IF HEALTH PLAN MEMBER, GIVE PLAN NAME	
PERS CHILD'S LAST NAME	FIRST	M	BIRTH	AGE	IF HEALTH PLAN MEMBER, GIVE PLAN NAME	
OTHER PERSON IN HOME: _____						
REQUESTED MEDICAL SERVICES: SERVICES? Y/N    TRANSPORTATION? Y/N    SCHEDULING? Y/N						
REQUESTED DENTAL SERVICES: SERVICES? Y/N    TRANSPORTATION? Y/N    SCHEDULING? Y/N						
REQUESTED ADDITIONAL INFORMATION BUT NO SERVICES? Y/N						
FAMILY DOCTOR: _____						
FAMILY DENTIST: _____						
FORM PM 357 <span style="float: right;">Revision Date: March, 1999</span>						

## CHDP Referral for Welfare Case Data System Counties

BD50120--5Z  
CDS286

COUNTY OF ALAMEDA  
WELFARE CASE DATA SYSTEM  
CHDP REFERRAL FORM

PM 357  
DEL 4/87  
CODE 4 SH EW WH6H  
ELIG. DET. DATE 4-14-00

CASE NAME LAST FIRST AID-T CASE NUMBER MS-X

PAYEE - PHONE NUMBER-

OAKLAND CA 94603-1602 LANGUAGE-

CASE REFERRED FOR- MEDICAL AND DENTAL WITH SCHEDULING/TRANSPORTATION

ELIGIBLE PERSONS IN CASE REFERRED

PERS NBR	FIRST	LAST	SEX	BIRTHDATE	HC
11	YAS.		F	8-13-92	N
12	ADT		M	9-28-97	N
13	UNBORN			9-25-00	N

**PART B: FOLLOW-UP TO HEALTH ASSESSMENT AND/OR DENTAL SERVICES**  
CONTACT ATTEMPT WITH RESPONSIBLE PERSON:

TYPE OF CONTACT	DATE	RESULT	WHO CONTACTED	DATE	RESULT	WHO CONTACTED
<input type="checkbox"/> FACE - TO - FACE						
<input type="checkbox"/> TELEPHONE						
<input type="checkbox"/> MAIL						

COMMENTS:

FINAL RESULT:

☐ CONTACT MADE

☐ NO CONTACT MADE

**PART B** CONTINUED ON REVERSE SIDE

## Confidential Referral/Follow Up Report (PM 161)

Online Version: [www.ca.gov/pcf/cms/chdp/publications.htm#pm161](http://www.ca.gov/pcf/cms/chdp/publications.htm#pm161)

State of California—Health and Human Services Agency		Department of Health Services Child Health and Disability Prevention Program	
<b>CHDP CONFIDENTIAL REFERRAL/FOLLOW-UP REPORT</b>			
<b>CHDP Health Assessment Provider:</b> <ul style="list-style-type: none"> <li>Retain original form in patient's medical record.</li> <li>Send photocopy to diagnosis/treatment provider.</li> </ul>		<b>Diagnosis/Treatment Provider:</b> <ul style="list-style-type: none"> <li>Complete and sign form. Retain the signed form in patient's medical record.</li> <li>If patient consent is given, send photocopy of completed and signed form to the CHDP Health Assessment Provider.</li> <li>If patient consent is given, send photocopy of completed and signed form to the local CHDP program. To find the mailing address for the local CHDP Program, go to <a href="http://www.dhs.ca.gov/chdp">www.dhs.ca.gov/chdp</a>.</li> </ul>	
<b>CHDP HEALTH ASSESSMENT PROVIDER COMPLETES THIS SECTION:</b>			
Patient name (Last) _____ (First) _____ (Initial) _____		BIC number _____	
Date of birth Month _____ Day _____ Year _____	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Patient's county of residence _____	Code _____ Telephone number _____
Responsible person (Name) _____ (Street) _____		(City) _____	(ZIP code) _____
<p>Dear _____ :</p> <p style="text-align: center; font-size: small;">(Diagnosis/Treatment Provider)</p> <p>The above named patient received a CHDP health assessment on _____. The following suspected condition(s) was identified as needing further evaluation: _____ (Date)</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>After you have seen and examined the patient, please note your findings below. If appropriate consent has been obtained below, please send a photocopy to me and/or the local CHDP program. Thank you,</p>			
Printed name of CHDP Health Assessment Provider _____		Signature _____ Date _____	
Mailing Address (street, number) _____		City _____	ZIP code _____ Telephone number _____
<b>PARENT COMPLETES THIS SECTION:</b>			
<b>CONSENT:</b> I have read the release of information disclosure on page 2 and I hereby authorize release of information to: <input type="checkbox"/> Local CHDP Program <input type="checkbox"/> CHDP Health Assessment Provider    _____ Signature of Responsible Person    Date _____			
<b>DIAGNOSIS/TREATMENT PROVIDER COMPLETES THIS SECTION:</b>			
A. What was your diagnosis (ICD terminology) of suspected condition 1?		What was your diagnosis (ICD terminology) of suspected condition 2?	
_____		_____	
ICD Code (optional) _____		ICD Code (optional) _____	
<b>B. Result of diagnosis: (Check appropriate line.)</b> <input type="checkbox"/> Abnormality not confirmed <input type="checkbox"/> Abnormality confirmed: <input type="checkbox"/> No treatment indicated <input type="checkbox"/> Treatment indicated—given <input type="checkbox"/> Treatment indicated—referred <input type="checkbox"/> Treatment indicated—not given nor referred <b>Reason:</b> _____		<b>Result of diagnosis: (Check appropriate line.)</b> <input type="checkbox"/> Abnormality not confirmed <input type="checkbox"/> Abnormality confirmed: <input type="checkbox"/> No treatment indicated <input type="checkbox"/> Treatment indicated—given <input type="checkbox"/> Treatment indicated—referred <input type="checkbox"/> Treatment indicated—not given nor referred <b>Reason:</b> _____	
Diagnosis/Treatment Provider signature 		Date examined Month _____ Day _____ Year _____ Diagnosis/Treatment Provider's telephone number ( ) _____	
PM 161 (4/03)		Page 1 of 2	

### **RELEASE OF INFORMATION DISCLOSURE**

To the responsible person:

When your child or you are referred for diagnosis and/or treatment as a result of a CHDP health assessment, this form will be used to assist in the referral. Certain information regarding the reason for referral will be written on this form.

The original will be kept in your child's or your confidential patient file by the CHDP health assessment provider, and a copy will be sent to the health care provider or agency providing diagnostic and/or treatment services.

The results of the diagnostic and/or treatment services will be recorded on the copy. It will be kept by the diagnostic and/or treatment provider in your child's or your confidential patient file. With your permission, copies will be distributed as follows:

- A copy will be sent to your local CHDP program to let them know that your child or you received the recommended services. The director or the deputy director of the local CHDP program at your local health department has the responsibility to maintain this copy as a confidential record.
- A copy will be sent to the CHDP health assessment provider to let this provider know that your child or you received the recommended services. This copy will be kept by the health assessment provider in your child's or your confidential patient file.

10-82

**RELEASE OF INFORMATION NOTICE TO THE RESPONSIBLE PERSON:**

The information provided on this form is voluntary and is used by the California Child Health and Disability Prevention (CHDP) program in accordance with Article 7, Subchapter 13, Title 17, of the California Administrative Code to monitor program quality, to reimburse providers of health assessments for their services, and to facilitate diagnosis and treatment at the local level for children found to have health problems. Information provided may be transferred to local health departments for follow-ups. Refusal to supply the information requested will hamper efforts to monitor this program, may delay reimbursement procedures, and may delay diagnosis and treatment of health conditions affecting your child. For access to records containing this information, you may contact the individual listed below. You may also request the location of this information and the categories of persons who use it.

Chief, Children's Medical Services Branch  
Primary Care and Family Health Division  
Department of Health Services  
P.O. Box 942732  
Sacramento, CA 94234-7320

(916) 327-1400

PM 160 (7/03)

10-84

**RELEASE OF INFORMATION NOTICE TO THE RESPONSIBLE PERSON:**

The information provided on this form is voluntary and is used by the California Child Health and Disability Prevention (CHDP) program in accordance with Article 7, Subchapter 13, Title 17, of the California Administrative Code to monitor program quality, to reimburse providers of health assessments for their services, and to facilitate diagnosis and treatment at the local level for children found to have health problems. Information provided may be transferred to local health departments for follow-ups. Refusal to supply the information requested will hamper efforts to monitor this program, may delay reimbursement procedures, and may delay diagnosis and treatment of health conditions affecting your child. For access to records containing this information, you may contact the individual listed below. You may also request the location of this information and the categories of persons who use it.

Chief, Children's Medical Services Branch  
Primary Care and Family Health Division  
Department of Health Services  
P.O. Box 942732  
Sacramento, CA 94234-7320

(916) 327-1400

PM 160 INFORMATION ONLY (7/03)

## Important Information for Persons Requesting Medi-Cal (MC 219)

Online Version: [www.dhs.ca.gov/publications/forms/pdf/mc219.pdf](http://www.dhs.ca.gov/publications/forms/pdf/mc219.pdf)

State of California—Health and Human Services Agency

Department of Health Services

### ENGLISH

## IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL

### PRIVACY AND CONFIDENTIALITY NOTIFICATION

Sections 14011 and 14012 of the Welfare and Institutions Code allow county welfare departments to get certain facts from you to decide if you, or the persons you represent, can get Medi-Cal benefits. You must provide these facts to get Medi-Cal benefits. The information will be used:

1. By the county welfare department to establish first-time and ongoing Medi-Cal eligibility.
2. By Administrative Vendor (AV) to process claims and make Benefits Identification Cards (BICs).
3. By the United States (U.S.) Department of Health and Human Services to make audit and quality control reviews and verify Medicare Buy-In and Social Security Numbers (SSNs).
4. To verify alien status with the U.S. Immigration and Naturalization Service (INS) only for aliens who claim to be lawfully admitted for permanent residence or Permanently Residing in the U.S. Under Color of Law (PRUCOL) or Amnesty Aliens with a valid and current I-688 card. The information the INS receives can only be used to determine Medi-Cal eligibility, and cannot be used for immigration enforcement unless you are committing fraud.
5. By medical services providers and health maintenance organizations to certify eligibility.
6. To identify health insurance coverage and take recovery actions.

### MEDI-CAL APPLICANT/BENEFICIARY RIGHTS, RESPONSIBILITIES, AND UNDERSTANDINGS

#### I HAVE THE RIGHT TO:

1. Ask for an interpreter to help me in applying for Medi-Cal if I have difficulty in speaking or understanding the English language.
2. Request a face-to-face interview with a county representative.
3. Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
4. Apply as a disabled person if I think I am disabled.
5. Receive information about the rules for retroactive Medi-Cal eligibility.
6. Apply for Medi-Cal and to be told in writing whether I qualify for any Medi-Cal program.
7. Review Medi-Cal program rules and regulation manuals if I want to question the basis on which my eligibility is approved or denied.
8. Have all facts that I give to the county welfare department kept in the strictest confidence and to look at those facts during regularly scheduled office hours.
9. Receive an immediate need card, **when possible and eligible**, if I have a medical emergency or I am pregnant.
10. Receive Medi-Cal, as authorized, while my satisfactory immigration status is being documented and verified, if I am otherwise eligible. **Aliens who are lawfully admitted for permanent residence or PRUCOL or Amnesty Aliens with a valid and current I-688 card are in a satisfactory immigration status.**
11. Receive information about the Child Health and Disability Prevention Program (CHDP) and the Special Supplemental Food Program for Women, Infants, and Children (WIC), and to ask for help in receiving those services.
12. Receive information about the Personal Care Service Program (PCSP), and to ask for help in receiving those services.
13. Receive information about the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT).
14. Ask for and receive information about the Family Planning Program and be told if I am eligible for those services.

**IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)**

15. Speak to a social worker about other public or private services or resources that I can get.
16. Receive information about Medi-Cal Health Care Plans that my family and I can join to get a doctor and other medical care, and to choose the option I prefer.
17. Lower my share of cost by providing past unpaid medical bills (that I still owe).
18. Reduce my property reserve to within the Medi-Cal property limit by the last day of a month for which I want Medi-Cal, including the month I apply, and to be told how I may spend my excess property.
19. Divide countable (nonexempt) community (MY SPOUSE's AND MY) property by written agreement into equal shares of separate property if either of us entered a long-term care (LTC) facility before September 30, 1989.
20. Keep a certain amount of countable separate and community property if I enter an LTC facility on or after January 1, 1990. My spouse and I have the right to be told the amount.
21. Have a state hearing if I am dissatisfied with an action taken (or not taken) by the county welfare department or the State Department of Health Services, except actions relating to the Health Insurance Premium Payment (HIPP) and Employer Group Health Plan (EGHP) programs. If I want a state hearing to appeal the decision, I must ask for it within **90 days** of the date the Notice of Action (NOA) was mailed to me. If I do not receive a NOA, I must request a hearing within **90 days** from the date I discover the action (or inaction) with which I am dissatisfied. The date of discovery is the date I know, or should have known, of the action. The best way to ask for a hearing is to contact the nearest county welfare department.

**I HAVE THE RESPONSIBILITY TO TELL MY COUNTY REPRESENTATIVE WITHIN TEN DAYS WHENEVER:**

1. Income received by me or any member of my family increases, decreases, starts, or stops. This includes income from Social Security Administration (SSA), loans, settlements, or any other source.
2. I plan to change or have already changed my place of residence or mailing address.
3. A person, including a newborn child, whether or not related to me or my family, moves into or out of my home.
4. An absent parent returns to the home.
5. I or a member of my family gives birth, becomes pregnant, or ends a pregnancy.
6. I, my spouse, or any member of my family enters or leaves a nursing home or an LTC facility.
7. I receive, transfer, give away, or sell real or personal property (including money), or when someone gives me or a member of my family such things as a car, house, insurance payments, etc.
8. I have any expenses that are paid for by someone other than myself.
9. I or a member of my family gets a job, changes jobs, or no longer has a job.
10. I have a change in expenses related to my job or education. (For example: child care, transportation, etc.)
11. I or a member of my family becomes physically or mentally impaired (this would include a child in the family).
12. I or a member of my family applies for disability benefits with the SSA, Veterans Administration, or Railroad Retirement.
13. One of my children drops out of school or returns to school.
14. There is a change in the citizenship/immigration status of any family member applying for or receiving Medi-Cal.
15. Health insurance coverage for me or a member of my family changes.

**I HAVE THE RESPONSIBILITY TO:**

1. Complete and return a status report by the date required when requested.
2. Give proof that I am a resident of California.

**IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)**

3. Make a declaration about my citizenship/immigration status.
4. Provide an SSN for myself and/or for any member of my family who has an SSN and wants Medi-Cal benefits. If I am a U.S. citizen, a U.S. national, or an alien in a satisfactory immigration status, I must apply for an SSN and provide it to the county if I do not already have one. If I need to apply for an SSN, I can get help from my eligibility worker, but I must work with the SSA to clear up any questions or my Medi-Cal will be denied or stopped. (Aliens who are not in a satisfactory immigration status and do not have an SSN can get **restricted Medi-Cal** without applying for an SSN if they meet all the rules.)
5. Apply for any income that may be available to me or any member of my family.
6. Apply for Medicare benefits if I am blind, disabled, have End Stage Renal Disease, or am 64 years and 9 months of age or older and eligible. I am responsible for telling my providers that I have both Medi-Cal and Medicare coverage.
7. Apply for and enroll in any health insurance if that is available to me and my family at no cost. I have the responsibility to remain enrolled in the health plan when Medi-Cal approves payment of plan premiums by the State of California.
8. Report to the county department, and to the health care provider, any health care coverage/insurance I carry or am entitled to use, including Medicare. If I willfully fail to give this fact, I may be guilty of a criminal offense, or may be billed by my provider.
9. Go to my health care plan (such as Kaiser, CHAMPUS, or a Medicare HMO) for medical care. (Medi-Cal will not pay for any services covered by the plan.)
10. Give any insurance payments I receive to the State if Medi-Cal has already paid for my care.
11. Go to a presentation, if presentations are given, and make a written choice, **or** answer if received by mail, about how I want to get my Medi-Cal benefits. If I do not go and make a choice, **or** choose by mail, my eligible family members and I may be signed up in a Medi-Cal Health Care Plan near my home.
12. Sign and date my BIC when I get it and ensure it is used only to get necessary health care for myself or eligible family members.
13. Take my BIC to my medical provider when I am sick or have an appointment. In emergencies when the BIC is not in hand, I must get the BIC to the medical provider when possible.
14. Report to the county department when I receive health care services because of an accident or injury caused by another person's action or failure to act, for which Medi-Cal has been, or may be billed.
15. Cooperate with the State or county in establishing paternity and identifying any possible medical coverage I or my family may be entitled to through an absent parent.
16. Cooperate with the State of California if my case is selected for review by the quality control review team. If I refuse to cooperate, my Medi-Cal benefits will be stopped.

**I UNDERSTAND THAT:**

1. Failure to give necessary facts or deliberately giving false facts can result in Medi-Cal benefits being denied or stopped. My case may also be investigated for suspected fraud.
2. The facts I give will be checked by computer with facts given by employers, banks, SSA, Franchise Tax Board, welfare, and other agencies. I will have the right to give proof to correct any facts which are found to be wrong.
3. Aliens who are not in a satisfactory immigration status and do not have an SSN can get **restricted** Medi-Cal without applying for an SSN if they meet all the rules.
4. Immigration status data given as part of the Medi-Cal application is confidential.
5. Based on my income, I will have to pay or be billed for part of my medical expenses before I can get Medi-Cal.
6. If I do not report changes promptly, and because of this, receive Medi-Cal benefits that I am not eligible for, I may have to repay the State Department of Health Services.

**IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)**

7. If I am receiving Medi-Cal based on disability and I apply for disability benefits from the **SSA, and the SSA** denies my disability claim, my Medi-Cal may be stopped. If I appeal my SSA denial right away, my Medi-Cal will continue until the SSA makes a final decision. If the SSA allows my claim, then my Medi-Cal benefits will continue. If the SSA does not allow my claim, then my Medi-Cal benefits will stop.
8. As a condition of Medi-Cal eligibility, all rights to medical support and/or payment for medical services for myself and any eligible persons that I have legal responsibility for, are automatically assigned to the State.
9. If medical support is court-ordered from an absent parent for my children, the insurance carrier must allow me to enroll and provide benefits to my children without the absent parent's consent.
10. If I don't apply for or keep no-cost health coverage or state-paid coverage, my Medi-Cal benefits and/or eligibility will be denied or stopped.
11. When I apply for Medi-Cal, I will be evaluated for potential eligibility under other medical assistance programs, including the HIPP and EGHP programs.
12. If I ask a Medi-Cal provider for any services not covered by my **non-Medi-Cal** health insurance plan, I must give the medical provider a written statement from my health plan saying it does not offer the Medi-Cal-covered services.
13. Medi-Cal providers cannot collect insurance copayment, coinsurance, or deductibles from me unless the payment is used to meet my Medi-Cal share-of-cost and/or copayment.
14. If I am admitted to a nursing facility and I have no intention of returning to my home, the State may impose a lien against my property.
15. After my death, the State has the right to seek reimbursement from my estate for all Medi-Cal benefits I received after age 55 unless I have a surviving spouse (during his or her lifetime), minor children, blind or permanently and totally disabled children, or it would create a hardship for my heirs.
16. After the death of my surviving spouse, the State has the right to claim from the part of his or her estate received from me, all Medi-Cal benefits I received after age 55 up to the amount of property my spouse received from my estate.

***Sign and keep for your records.***

I hereby state that I have reviewed the information on this form with the county representative and that I fully understand my RIGHTS AND RESPONSIBILITIES to have my eligibility determined for Medi-Cal and to maintain that eligibility.

➤ \_\_\_\_\_ Date \_\_\_\_\_  
Applicant/Representative Signature (optional)



**COUNTY USE SECTION**

I have provided (check one) ☐ In person ☐ By mail to the applicant the rights, responsibilities, and other information listed on this form.

➤ \_\_\_\_\_ Worker Number \_\_\_\_\_ Date \_\_\_\_\_  
Eligibility Worker's Signature

State of California – Health and Human Services Agency

Department of Health Services

**NOTE:** The Temp 602 B CHDP/FP Questionnaire form is no longer in use since the end of the option for CalWORKs Redetermination by mail. However, this form may be useful when considering strategies for informing those persons who apply to Medi-Cal Only by mail.

**Medical and Dental Exams for Children and Youth and Family Planning Services  
(TEMP 602 B)**

**Please read the enclosed booklets. If you have any questions about the Child Health and Disability Prevention (CHDP) Program, please call the number listed on the back of the CHDP booklet. If you have any questions about Family Planning, please call toll-free 1-800-942-1052.**

Your answers to the following questions will not affect your eligibility for cash aid.

- a. Members of your family who are under age 21 and on Medi-Cal are eligible for free medical and dental exams. The medical exam includes a complete physical, immunizations (shots), eye and hearing tests, and information about growth and development. Regular medical and dental exams help protect your family's health and are available upon request through the CHDP program.

Please check box if you want:

- More information about CHDP services. ☐ Yes
- More information about immunization services. ☐ Yes
- A medical exam for your children. ☐ Yes
- A dental exam for your children. ☐ Yes
- Help making an appointment or getting to the doctor or dentist. ☐ Yes

- b. Do you or any family members want free or low-cost family planning services to help plan how to prevent unplanned pregnancies and/or have the next child? If "YES", call your health care plan or regular doctor. Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054.

☒ Please print your name, address, telephone and social security numbers in the space below. Return this form with your next Monthly Income Eligibility form.

Name:	_____	Telephone Number:	(    )	_____
Address:	_____	Social Security Number:	_____	_____
City:	_____	Zip Code:	_____	_____

Temp 602B CHDP/FP Questionnaire

Revision Date March 1999

## Medi-Cal/Healthy Families Mail-In Application (MC 321 HFP)

Online Version: [www.mrmib.ca.gov/MRMIB/HFP/HFPApplication.pdf](http://www.mrmib.ca.gov/MRMIB/HFP/HFPApplication.pdf)



### A Healthier Tomorrow Starts Today

## CALL TOLL-FREE, 1-800-880-5305

### Use This Mail-In Application To Apply For



**No-Cost  
Health Coverage for Children,  
Birth Through Age 18,  
and Pregnant Women**

- No-cost comprehensive health, dental and vision benefits for children.
- No monthly premiums.
- No copayments for any benefit.
- Choice of health insurance plans in most major population centers.
- Family property (such as savings or cars) does not count for eligibility.
- More children with higher family incomes qualify for **no-cost Medi-Cal**.
- Available for children of single or two-parent working families.
- Mail-in application. Does not require a visit to the welfare office to apply.



**Low-Cost  
Health Coverage  
for Children  
Birth Through Age 18**

- Low-cost comprehensive health, dental and vision insurance.
- Low monthly premiums from \$4 per child to a maximum of \$27 per family.
- No copayment for preventive services (such as immunizations). \$5 copayment for non-preventive services (such as going to the doctor due to illness).
- Choice of health, dental and vision insurance plans.
- Family property (such as savings or cars) does not count for eligibility.
- For children without health insurance and children on **Medi-Cal with a cost**.
- Available for children of single or two-parent working families.
- Mail-in application.
- Apply up to 3 months in advance for an unborn child, or a child who will turn 1 or 6 years old and lose **no-cost Medi-Cal**.

**Medi-Cal and Healthy Families are two health care programs:**

- Family size, age of the child and income determine which program a child may qualify for. A younger child may qualify for **no-cost Medi-Cal** and an older child may qualify for **Healthy Families**.
- If the child qualifies for **no-cost Medi-Cal** he/she **does not qualify** for **Healthy Families**.
- If your income is too high to be eligible for **no-cost Medi-Cal**, your **child may qualify** for **Healthy Families**.


**To be eligible for Medi-Cal or Healthy Families using this form, a person must be:**

- Under age 19, or a pregnant woman
- Within income guidelines
- A California resident
- A U.S. citizen, national or eligible alien. Regardless of immigration status or date of entry, a child or pregnant woman can qualify for some form of **Medi-Cal**.

MC 321 HFP (rev. 10/99)  
INSTRUCTIONS

10-91

**HOW TO APPLY:**

To apply, you **do not** have to figure out what program(s) the child or pregnant woman is eligible for. 

- Just fill out application pages A1-A3 and mail it with all required documents.
- If it appears your child is eligible for **Healthy Families**, you may also fill out page A4. Mail all 4 pages (A1-A4), with a premium payment and all required documents. You can do this now or we will contact you after we determine your child is eligible. If you fill it out now, coverage will start sooner.

**DO YOU NEED HELP? ALL HELP IS FREE!**

If you want to know which program you qualify for **before** you sign and submit your application, or you need help completing the application, call us **toll-free, 1-800-880-5305**. Our operators can also give you the name and telephone number of a trained Certified Application Assistant in your community.

**GROSS MONTHLY INCOME**


You do not have to know which program your child may qualify for, but you can use the chart below if you want an idea. If your family's monthly income is at or below the amount shown, your child may qualify for **Healthy Families** or **no-cost Medi-Cal**. If you work, pay for child care, or pay/receive child support and/or alimony, we will reduce the family's income level. Family income, family size and allowable deductions are explained throughout these instructions. For information about larger families, call us **toll-free, 1-800-880-5305** or ask a **Certified Application Assistant**.


FAMILY SIZE	CHILD BIRTH UP TO AGE 1 OR PREGNANT WOMAN MEDI-CAL	CHILD BIRTH UP TO AGE 1 HEALTHY FAMILIES	CHILD AGE 1 THRU 5 MEDI-CAL	CHILD AGE 1 THRU 5 HEALTHY FAMILIES	CHILD AGE 6 THRU 18 MEDI-CAL	CHILD AGE 6 THRU 18 HEALTHY FAMILIES
1	\$0 - \$1,477	\$1,478 - \$1,846	\$0 - \$982	\$ 983 - \$1,846	\$0 - \$ 739	\$ 740 - \$1,846
2	\$0 - \$1,990	\$1,991 - \$2,488	\$0 - \$1,324	\$1,325 - \$2,488	\$0 - \$ 995	\$ 996 - \$2,488
3	\$0 - \$2,504	\$2,505 - \$3,130	\$0 - \$1,665	\$1,666 - \$3,130	\$0 - \$1,252	\$1,253 - \$3,130
4	\$0 - \$3,017	\$3,018 - \$3,771	\$0 - \$2,007	\$2,008 - \$3,771	\$0 - \$1,509	\$1,510 - \$3,771
5	\$0 - \$3,530	\$3,531 - \$4,413	\$0 - \$2,348	\$2,349 - \$4,413	\$0 - \$1,765	\$1,766 - \$4,413
6	\$0 - \$4,044	\$4,045 - \$5,055	\$0 - \$2,689	\$2,690 - \$5,055	\$0 - \$2,022	\$2,023 - \$5,055

**APPLICATION INSTRUCTIONS****SECTION 1**

Tell us about the person applying for the child, the pregnant woman, the unborn child, or him or herself.

**Question 16**

We encourage you to take advantage of health care for your children regardless of which program they qualify for. 

- **Children:** We will enroll your child in the program he/she is eligible for unless you tell us not to. If you do not want your child enrolled in one of these programs, tell us by checking the box of the program you do not want. This means if you check the **Medi-Cal** box and your child is eligible for **Medi-Cal**, he or she will not get health care coverage from either program. 

- **Pregnant Women:** The Access for Infants and Mothers (AIM) program provides health care to uninsured pregnant women whose income is too high to qualify for **no-cost Medi-Cal**. AIM also provides health care for the baby for up to 2 years. For more information and an application for AIM, call **1-800-433-2611**.

**SECTION 2**

Tell us about the children under 19 and/or the pregnant woman who want health coverage.

Answer Questions 17-32 for each child or pregnant woman wanting health coverage. If you are applying for an unborn child, check the box for unborn child under the **Child 1** column and tell us all the information you know at this time. Coverage for the unborn child will begin after **Healthy Families** receives documentation of the child's birth. To add more children, use a separate piece of paper or a photocopy of pages A1 and A2 of the application.

**Question 18** 



Answer this question if it is different from the answer for Question 17.

**Question 19**

Write the complete address including Street Number and Name, Apartment Number, City and Zip Code, if different from Section 1.

**Question 20** 

How is each child or pregnant woman related to the person in Section 1, Question 1. **For example:** daughter, spouse, stepchild, nephew, etc.

		<h1>APPLICATION</h1> <p>Please use the instructions to complete this application. Print clearly. Use black or blue ink only.</p>																																																																																																			
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TEAR HERE	1 LAST NAME		FIRST NAME		MIDDLE INITIAL																																																																																																
	3 HOME ADDRESS (NUMBER AND STREET). <b>DO NOT USE A P.O. BOX</b>			4 APARTMENT NUMBER	5 BIRTHDATE MO / DATE / YR																																																																																																
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**SECTION 2: Continued**

	Child 1 or Unborn <small>Check box <input type="checkbox"/> if unborn</small>	Child 2	Child 3	Child 4	Pregnant Woman
<b>27</b> Mother's Name:					
Last					
First					
Does the mother live in the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>28</b> Father's Name:					
Last					
First					
Does the father live in the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>29</b> Name of teen's spouse or pregnant woman's husband: <i>(If living in the home)</i>					
<b>30</b> Does any person(s) being applied for have <b>no-cost Medi-Cal</b> ? If "yes", give date coverage ends/ended.	<input type="checkbox"/> Yes <input type="checkbox"/> No MO / DATE / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No MO / DATE / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No MO / DATE / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No MO / DATE / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No MO / DATE / YR
<b>31</b> Does the pregnant woman and/or children have other health, dental or vision insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>32</b> Were any of the children insured by an employer in the last 90 days?  If "yes", check the main reason why health insurance stopped and give the date it stopped.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Lost job <input type="checkbox"/> Moved and no insurance available <input type="checkbox"/> Employer ended benefits to all employees <input type="checkbox"/> COBRA coverage ended <input type="checkbox"/> Other MO / DATE / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Lost job <input type="checkbox"/> Moved and no insurance available <input type="checkbox"/> Employer ended benefits to all employees <input type="checkbox"/> COBRA coverage ended <input type="checkbox"/> Other MO / DATE / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Lost job <input type="checkbox"/> Moved and no insurance available <input type="checkbox"/> Employer ended benefits to all employees <input type="checkbox"/> COBRA coverage ended <input type="checkbox"/> Other MO / DATE / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Lost job <input type="checkbox"/> Moved and no insurance available <input type="checkbox"/> Employer ended benefits to all employees <input type="checkbox"/> COBRA coverage ended <input type="checkbox"/> Other MO / DATE / YR	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Lost job <input type="checkbox"/> Moved and no insurance available <input type="checkbox"/> Employer ended benefits to all employees <input type="checkbox"/> COBRA coverage ended <input type="checkbox"/> Other MO / DATE / YR

**SECTION 3: Family members living in the home. Family size is taken into consideration when determining which program your children are eligible for.**

**33** List any other children living in the home under age 21 who are not listed in Section 2. Give their relationship to the person in Section 1, Question 1.

_____ LAST NAME, FIRST NAME	_____ RELATIONSHIP	_____ LAST NAME, FIRST NAME	_____ RELATIONSHIP
_____ LAST NAME, FIRST NAME	_____ RELATIONSHIP	_____ LAST NAME, FIRST NAME	_____ RELATIONSHIP

**34** Are any family members who are living in the home pregnant? ☐ Yes ☐ No

If yes, who: \_\_\_\_\_ Date Due: \_\_\_\_\_

**35** List any stepparent living in the home not already listed: \_\_\_\_\_  
LAST NAME, FIRST NAME

**36** Do any of the people listed in this Section, or any of the parents listed in Section 2, want **Medi-Cal**? ☐ Yes ☐ No

**SECTION 4: List the gross income (before taxes) of all persons listed in Section 2, Questions 17, 27, 28, 29 and Section 3 who live in the home. If self-employed or using federal income tax return to prove income, only complete Questions 37, 38 and 40 in this section.**

37	NAME OF PERSON WITH INCOME	38	SOURCE OF INCOME?	39	HOW OFTEN RECEIVED?	40	HOW MUCH GROSS INCOME?	41	SOCIAL SECURITY # (Optional)
1.									
2.									
3.									
4.									

**SECTION 5: Deductions from Family Income. The answers in this section will help determine what amounts will be deducted from your family's gross monthly income.**

42	TYPE OF PAYMENT YOUR FAMILY MAKES	43	NAME OF PERSON WHO PAYS	44	MONTHLY AMOUNT PAID
	Child Support				
	Alimony				

45	CHILD CARE OR DEPENDENT CARE (List child's name)	46	AGE	47	MONTHLY AMOUNT PAID
1.					
2.					
3.					
4.					

**SECTION 6: Other Coverage.**

48 Has anyone filed a lawsuit because of an accident or injury on behalf of the pregnant woman and/or child applying for benefits? ☐ Yes ☐ No

49 Does the pregnant woman and/or child want to apply for Medi-Cal coverage for any unpaid medical expenses in the last 3 months? ☐ Yes ☐ No

If "yes", list month(s): \_\_\_\_\_

**SECTION 7: Voluntary Information. Not required. Your answers will not affect your eligibility but they will help the state to get additional federal money to pay for health care programs.**

50 Is there more than one car in the children's household? ☐ Yes ☐ No

51 Is there more than \$3,150 cash in bank accounts in the children's household? ☐ Yes ☐ No

**SECTION 8: Signature and Certification.**

52 I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application, the declarations made, and the documents submitted are true and correct to the best of my knowledge and belief. I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_  
(if person signed with a mark)

Authorized Representative (if any) \_\_\_\_\_ Date \_\_\_\_\_

**SECTION 9: Reimbursement for Application Assistance. For Certified Application Assistant use only.**

53 I certify I had help completing this form from the Certified Application Assistant listed below. This CAA help was **FREE** of charge. The state will not issue a reimbursement to the EE unless Section 9 is completely and correctly filled out at the time this application is submitted.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

CAA Signature \_\_\_\_\_ CAA# \_\_\_\_\_ EE# \_\_\_\_\_ Date \_\_\_\_\_



If it appears you qualify for **Healthy Families** and want to choose your health, dental and vision plan now, fill out this page. Otherwise, we will contact you later for this information. See your **Healthy Families Handbook** for more information, or visit our web site at [www.healthyfamilies.ca.gov](http://www.healthyfamilies.ca.gov).

#### SECTION A: Health, Dental and Vision Plan Choices.

54	Health Plan/Code	55	Dental Plan/Code	56	Vision Plan/Code
57 Name of Doctor/Clinic (optional)		58 Doctor/Clinic Code (optional)		59 Name of Dentist/Clinic (optional)	
				60 Dentist/Clinic Code (optional)	

#### SECTION B: Rural Demonstration Project.

61	<p>If you are in any of these groups, there is a new statewide health, dental and vision plan combination offered to you. You can pick this new combination and put the code in the box below. See the <b>Healthy Families Handbook</b> for the combination code number.</p> <p>Check all boxes that apply to you.</p> <p><input type="checkbox"/> Native American Indian <b>OR</b> Working in seasonal or migratory jobs: <input type="checkbox"/> Agriculture <input type="checkbox"/> Forestry <input type="checkbox"/> Fishing</p>	Plan Combination Code
----	--	-----------------------

#### SECTION C: Healthy Families Declarations

##### I declare that each person I am applying for:

- is a resident of California.
- is not in jail or in a mental hospital.
- is not eligible for Medicare Part A and Part B.
- is not a member of a family that is eligible for health benefits from the California Public Employees Retirement System Health Benefits Program(s).

##### I further declare that:

- all individuals listed on this application will abide by the rules of participation, the utilization review process and the dispute resolution process of the participating plans in which the individual is enrolled.
- I have read and understand the **Healthy Families Handbook**. I understand what it says about each health, dental and vision plan and the benefits they offer.

- I am applying for all of my children eligible for **Healthy Families**, unless they are already enrolled, or I am 18 years old or a minor and applying for myself.

- I agree to pay 6 monthly premiums. If I do not pay the premiums, I will be taken off the program and cannot participate again for 6 months. I will have to pay for any **Healthy Families** services I use in the last month after coverage ended.

- I give permission to **Healthy Families** to check my family income, health coverage, immigration status of the people I am applying for, and all other facts on this application.

- I agree to notify the program within 30 days of any change of address of any person applied for who is accepted into the program and any change in the applicant's billing address.

#### SECTION D: Privacy Notice.

The Information Practices Act of 1977 and the Federal Privacy Act require the **Healthy Families** Program to provide the following notice to individuals who are asked by **Healthy Families** to supply information:

Personal and medical information requested is for subscriber identification and program administration purposes only. Program regulations under Title 10, CCR, Section 2699.6600 require that every individual furnish certain information when applying to the **Healthy Families** Program. Subscriber's information may be shared with State and local agencies involved in the administration of health programs. Information (including immigration status) about persons who do not become subscribers, will be used only for purposes of eligibility determination and program administration. Failure to furnish this information may result in the return of the application as incomplete.

The following information on the application is not mandatory: social security number, ethnicity information (unless the subscriber is a Native American Indian) and any other item marked voluntary or optional. An individual has a right to access records containing his/her personal information that are maintained by the Managed Risk Medical Insurance Board. The official responsible for maintaining the information is the Deputy Director of Eligibility and Enrollment, Managed Risk Medical Insurance Board, 1000 G Street, Room 450, Sacramento, California 95814, (916) 324-4695.

#### SECTION E: Resolving Disputes.

If you enroll in certain plans you agree to have certain claims (which may include medical malpractice claims) decided by neutral binding arbitration. Members give up their right to a jury or court trial. The **Healthy Families Handbook** has information about each plan and the arbitration requirements. You may call the plans you choose to find out more.

#### SECTION F: Signature and Certification.

62	I certify that I have read and understand the information above. I also certify that the information I have given on this form is true and correct.	
	Signature _____	Date _____
	Witness Signature _____	Date _____
	(If person signed with a mark)	

## APPLICATION INSTRUCTIONS

### SECTION 2 Continued

#### Question 23

Write the place of birth for each child or pregnant woman. If born in California, write the name of the county. If born outside of California, write the name of the state. If born outside the United States, write the name of the country.

#### Question 24

Use the chart below to find the ethnic code number or letter to answer Question 24. Giving an ethnic code is optional unless Native American Indian.

Ethnic Codes				
1 White	A	Amerasian	N	Asian Indian
2 Hispanic	C	Chinese	P	Hawaiian
3 Black/African American	H	Cambodian	R	Guamanian
4 Asian	J	Japanese	T	Laotian
5a Native American Indian	K	Korean	V	Vietnamese
5b Alaskan Native	M	Samoan	Z	Other
7 Filipino				

#### Question 25

- Immigration information we get as part of this application is private and confidential. The State will use this information only for eligibility determination and program administration. (See Privacy Notifications.)

**Medi-Cal** and **Healthy Families** do not collect information on the immigration status of parents/guardians who are not seeking health coverage for themselves. These programs cannot and will not provide information on the immigration status of such parents to the INS or use immigration information to demand or collect repayment information from recipients for services lawfully received.

- Give immigration information **only** for the people applying for health coverage. Do not give information for people (such as parents) who are not applying.
- Many immigrants can qualify for **Healthy Families** and **Medi-Cal**.

For **Healthy Families**: children must be eligible qualified aliens. The **Healthy Families Handbook** explains which aliens may be eligible and lists different types of immigration status.

For **Medi-Cal**: undocumented children and pregnant women can get pregnancy-related and emergency services. Immigrants who meet all income and immigration requirements can get **complete Medi-Cal benefits**.

#### Question 26

- Social Security numbers **are not required** for **Healthy Families** or for persons who want **Medi-Cal** for emergency or pregnancy related services only.



- The Social Security number of each child, teen or pregnant woman applying for **complete Medi-Cal benefits** is required.

- If you do not have a Social Security number and want **complete Medi-Cal benefits**, you can apply now and provide the number within the next 60 days.

- For more information on how to apply for a Social Security number, please call the Social Security Administration **toll-free, 1-800-772-1213**.

#### Question 27

Write the name of the mother of each child and/or the pregnant woman. If the mother is the same for all children, write her name for child 1, write "same" for the other children and/or pregnant woman.

#### Question 28

Write the name of the father of each child and/or the pregnant woman. If the father is the same for all children, write his name for child 1, write "same" for the other children and/or pregnant woman.

#### Question 29

Write the name of the spouse of the teen if the spouse is living in the home. Write the name of the pregnant woman's husband if her husband is living in the home.

#### Question 30

If the child had or now has **no-cost Medi-Cal** and the county sent a notice stating that the child now has or will have **Medi-Cal with some cost**, check "yes". Give the date the **no-cost Medi-Cal** coverage will end for each person. If the answer is "no", check "no".

#### Questions 31 and 32

- For **Medi-Cal**: You can get **no-cost Medi-Cal** and still have other health coverage. **Medi-Cal** may cover what your other insurance does not.
- For **Healthy Families**: Your child will not be eligible for **Healthy Families** if he/she has employer-sponsored health insurance.

### SECTION 3

**Family members living in the home.** Family size is used to determine which program your children are eligible for.

**Who counts as an adult family member?**

- natural or adoptive parents of the child who would get benefits
- husband of the pregnant woman applying
- pregnant woman
- emancipated minor or minor living on their own and self supporting

**Who counts as natural and adoptive children?**

- unborn child
- all children under age 21 living in the home
- all children under age 21 away at school and claimed as tax dependents

**Do not count** family members who get public assistance such as **SSI/SSP** or **CalWORKs**.

#### Question 33

Children under 21 years of age living in the home are counted as family members in family income calculation. **For example:** if there are two children listed in Section 2 and two children listed in Section 3, we may be able to count four children in the home instead of two. List the brothers, sisters, stepbrothers, stepsisters in the home who are not listed in Section 2, Question 17 (child 1, child 2, child 3 or child 4).

#### Question 34

Prenatal care is important for all pregnant women. The answer to this question will help a **Medi-Cal** program representative identify pregnant women's applications and process them faster.

#### Question 35

The answer to this question will help us figure your correct family income.

#### Question 36

Check "yes" if a brother/sister, stepbrother/sister between the ages of 19-21, or a parent or stepparent want **Medi-Cal** coverage. If you check "yes", you will be contacted for more information.



### SECTION 4

**List income of all persons in Section 2 and 3 who live in the home. This information is used to determine which program you are eligible for.**

#### Question 37

Use a separate line for each person who gets income. If a person gets income from two different sources, use two lines. **For example:** If Maria has two jobs, use one line for each job to report her earnings.

#### Question 38

List where the income comes from. **For example:** income could come from work (employer or self employment); child support from a parent who is not in the home; alimony from an ex-spouse; benefit payments from government agencies such as Social Security Retirement Survivor Disability Insurance and Veterans Administration; insurance policies; pension funds; rental properties; and gifts from relatives and friends, etc. If you have questions about what income to list, please call **toll-free, 1-800-880-5305**.

Do not list as income SSI/SSP payments; foster care payments for foster children in your care; college work study; CalWORKs payments (replaces AFDC); loans; and earnings of a child under age 14 or who goes to school.

#### Question 39

How often is this income received?

**For example:** once-a-week (weekly), every two weeks, two times a month, once a month, once a year, etc.

#### Question 40

- Write the amount of income you get each time. **For example:** if the income is received once a week, write the weekly amount in the box.
- If the income amounts change from time to time, put the average amount received on a regular basis. We will use the paystubs or other documents you give us to figure out the correct monthly income.
- If you know your family's income will go up or down **in the next few months** due to overtime, promotion, raises in pay, expected increases in child support/alimony, layoffs, furloughs, etc., explain on a separate sheet of paper. **For example:** Maria's income from her job this month is \$1000 but her regular monthly pay is only \$800. Explain on the paper that Maria's paycheck included \$200 overtime pay (or a \$200 bonus), and how long the overtime will last (how often she gets bonuses).
- If self-employed, write the net profit from Schedule C of last year's federal income tax return. Or give the last 3 months' profit and loss statements.
- If using last year's federal income tax return, add all income amounts reported. Do not deduct losses.

#### Question 41

- Social Security numbers are optional for this question.



## SECTION 5

### Deductions From Family Income.

The answers in this section help us determine what amounts we will use to lower your family's monthly income.

#### Question 42

We will deduct payments for court-ordered **child support or alimony** from the family's income.

#### Question 43

Write the name of the person who pays the child support or alimony.

#### Question 44

Write in the total amount the parent of the child or spouse of the pregnant woman (listed in Section 2) pays in one month for child support or alimony.

#### Question 45

Write in the name of each person receiving child care or dependent care.

#### Question 47

Write in the total amount that is paid in one month for each child or disabled dependent.

We will deduct payments for **child care and/or disabled dependent care** from the family's income if:

- the payments are made by a parent of the child or spouse of the pregnant woman (listed in Section 2); and
- the parent of the child or spouse of the pregnant woman (in Section 2) is working or in job-training and no one in the home can provide care.

**We will not deduct more than the maximum allowed for each child's care or disabled dependent's care.** Maximums depend on the age of the person receiving care.

Monthly maximum deductible amounts for each child and disabled dependent are:

<b>Child under the age of 2</b>	<b>= \$ 200</b>
<b>Child age 2 and older</b>	<b>= \$ 175</b>
<b>Disabled dependent of any age</b>	<b>= \$ 175</b>

#### WORK EXPENSE DEDUCTIONS

Up to a \$90 deduction will be given for each person in your family listed in Section 4 working or receiving State Disability Insurance or Workers Compensation.

#### CHILD SUPPORT AND ALIMONY DEDUCTIONS

If you get income from child support or alimony, a \$50 deduction from your family income will be made.

## SECTION 6

### Other Coverage.

#### Question 48

If **Medi-Cal** pays for medical services you need because of accident or injury, the costs may be taken out of the lawsuit settlement if you received money.

#### Question 49

**Medi-Cal** may be able to help pay for some unpaid medical expenses you have had in the 3 months before you completed this application.

- Even if you are applying for **Healthy Families** and have unpaid medical expenses in the 3 months before you completed this application, **Medi-Cal** may be able to help.
- If you check "yes", a **Medi-Cal** representative will call you for more information.

## SECTION 7

### Voluntary Information.

#### Questions 50 and 51

You do not have to answer these questions.

## SECTION 8

### Signature and Certification.

#### Question 52

State and federal laws require your signature on this application form. Your signature in this section indicates that your declarations and answers are truthful and the documents you submit are true and correct.

## SECTION 9

### Application Assistance.

#### Question 53

Complete this box **only** if you had help from a trained Certified Application Assistant.





## FILLING OUT THE HEALTHY FAMILIES PAGE

### Questions 54 through 62

Answer these questions if your children appear to be eligible for **Healthy Families** and you want their health coverage to begin as soon as possible. Otherwise, we will contact you later for this information. The **Healthy Families Handbook** has important information about the program, the plans in your county, selecting a doctor or dentist and premium payments. Use the **Handbook** to select a health, dental and vision plan.



Send your first month's premium payment with the application, pages A1-A4. If you pay premiums for 3 months at one time now, your fourth (4th) month is **FREE!** Make your premium payment payable to the **Healthy Families** Program. Personal checks, money orders and cashier's checks are fine. Sorry, we do not accept cash. See the **Healthy Families Handbook** to find out what your monthly premium will be. If your child is not eligible for **Healthy Families**, your premium payment will be refunded to you.



To request a copy of the **Healthy Families Handbook**, please call toll-free, 1-800-880-5305. Visit our web site at [www.healthyfamilies.ca.gov](http://www.healthyfamilies.ca.gov).

## WHAT DOCUMENTS ARE NEEDED

- **A copy of the birth certificate** for any U.S. citizen or national applying for health coverage. Send it now or within 60 days of enrollment.

OR

- **Proof of immigration status** or a receipt from the INS showing you have applied to replace a lost document. Only persons seeking health coverage should send a copy of the document showing date of entry (both sides) or receipt now or within 30 days of enrollment. If the child or pregnant woman does not have any immigration documents, he/she may still be eligible for emergency or pregnancy related **Medi-Cal** services.



- **Proof of the deductions** listed in Section 5. For child care and dependent care, send receipts or cancelled checks.
- **Proof of California residency.** You can use your proof of income as proof of residency, too. If your income is not from California, send other proof of residency.
- If pregnant, or applying for an unborn child, **proof of pregnancy** from a doctor or clinic.
- **Proof of income.** Send a copy of the most recent paystub. If a paystub is not available, get a signed statement from employer. Gross monthly income and the dates received should be on the statement.

OR

Send a **copy of last year's federal income tax return.**



**Other proof of income you may need to send:**

- If a person is self-employed, send last year's federal income tax return (with a Schedule C) or the last **3 months' profit and loss statements.**
- If a person has income such as **disability or retirement**, send **copies of award letters or bank statements** showing the direct deposits.
- If anyone gets **child support and/or alimony** or spousal support, send **copies of the checks** received or **statements from the District Attorney's Family Support Division**, for the last month.
- For **Healthy Families** only: A **Medi-Cal "Share-of-Cost Notice of Action"** received in the last 30 days which shows the child has share-of-cost, may be used as proof of income.



#### Medi-Cal Confidentiality Notice:

The information given in this application is private and confidential under Welfare and Institutions Code Sections 10850 and 14100.2. The information will be disclosed only in accordance with those laws.

#### Medi-Cal Rights, Responsibilities and Declarations:



##### I have the right to:

- be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
- ask for an interpreter.
- ask for a fair hearing if I think a decision on my Medi-Cal case is unfair or wrong. I must ask for a hearing within 90 days after I get a "Notice of Action". To find out about Medi-Cal fair hearings, call toll-free, 1-800-952-5253.



##### I have the responsibility to:

- send in a status report when the county asks me to.
- report any changes within 10 days in the information I gave on this application.
- let the county know if a family member: applies for disability benefits; is in a public institution; or gets medical care for any accident or injury caused by another person.
- cooperate if my case is reviewed.

##### I declare that each person I am applying for:

- lives in California and plans to stay here.
- does not own or lease a principal residence outside California.
- is not getting public assistance from outside California.
- is not in jail, prison, or any other correctional facility.



##### I further declare that:

- I understand that as a condition of Medi-Cal eligibility, all rights to medical support are automatically assigned to the State of California.
- If I am not eligible for this Medi-Cal program, I understand I may qualify for other programs and have the right to apply for them.
- If I purposely do not give needed facts, or if I give false facts, I understand benefits may be denied or ended and repayment may be required. I may also be investigated for fraud.

#### Medi-Cal Privacy Notice:

The Information Practices Act of 1977 and the Federal Privacy Act require the Department of Health Services to provide the following information: Welfare and Institutions Code section 14011 and regulations in Title 22, CCR, require applicants for the Medi-Cal program to provide the eligibility information requested in this application. This information may be shared with federal, state, and local agencies for purposes of verifying eligibility and for other purposes related to the administration of the Medi-Cal program, including confirmation with the INS of the immigration status of only those persons seeking full scope Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except in cases of fraud.) The information will be used by Electronic Data Systems to process claims and make Benefits Identification Cards (BICs). Failure to provide the required information may result in denial of the application.



Information required by this form is mandatory, with the exception of ethnicity information, and any other item marked voluntary or optional. Social Security Numbers are required by Section 1147(a)(1) of the Social Security Act and by Welfare and Institutions Code Section 14011.2, unless applying for emergency or pregnancy related benefits only.

An individual has a right of access to records containing his/her personal information that are maintained by the Department of Health Services. Contact your county health and human services/ social services office to request your records.



For Help In Your Language...Please

Call Toll-Free, 1-800-880-5305

1

English

2

Spanish

3

Vietnamese

4

Cambodian

5

Hmong

6

Armenian

7

Cantonese

8

Korean

9

Russian

0

Farsi

Provided by the State of California

PUB: 326 (rev. 10/99)

English

**Quarterly Report of Medi-Cal Recipients Requesting CHDP Services**

<b>County/City</b>	<b>Fiscal Year</b>
<b>Reporting Quarter</b>	
<b>Beginning Month</b>	<b>Ending Month</b>
Number of CalWORKS and Foster Care (AFDC) Recipients Requesting CHDP Services	
Number of Medi-Cal Only Recipients Requesting CHDP Services	
<b>Total</b>	

---

**Signature of CHDP Representative**

Send to:      Program Support Section Chief  
Children's Medical Services Branch  
MS 8104  
P.O. Box 997413  
Sacramento, CA 95899-7413

## Statement of Citizenship, Alienage, and Immigration Status (MC 13)

Online Version: [www.dhs.ca.gov/publications/forms/pdf/mc013.pdf](http://www.dhs.ca.gov/publications/forms/pdf/mc013.pdf)

<p style="font-size: small;">State of California—Health and Human Services Agency</p>	<p style="font-size: small;">Department of Health Services</p>
<b>STATEMENT OF CITIZENSHIP, ALIENAGE, AND IMMIGRATION STATUS</b>	
Print name of applicant (the applicant is the person who wants Medi-Cal)	Date
Print name of person acting for applicant	Relationship to applicant

**SECTION A: MEDI-CAL BENEFITS TO CITIZENS AND ALIENS**

Citizens and nationals of the United States who meet all eligibility requirements may receive full Medi-Cal benefits.

Aliens who meet all eligibility requirements may receive either full Medi-Cal benefits (if they are in a satisfactory immigration status) or restricted benefits limited to emergency and pregnancy-related services (if they are not in a satisfactory immigration status).

**Satisfactory immigration status and full Medi-Cal benefits for aliens:** Federal and state law provide that *full* Medi-Cal benefits may be received only by aliens who are in a satisfactory immigration status and who meet all eligibility requirements including California residency. Aliens are in a satisfactory immigration status if they are amnesty aliens with valid and current lawful temporary resident cards (I-688) or lawful permanent residents or permanently residing in the U.S. under color of law (PRUCOL). The 16 PRUCOL categories are listed in SECTION B, question 6 below.

Documented aliens not in a satisfactory immigration status who meet all eligibility requirements, including California residency, may receive restricted benefits (limited to emergency and pregnancy-related services).

Undocumented aliens who meet all eligibility requirements, including California residency, may receive restricted benefits (limited to emergency and pregnancy-related services).

**Citizenship/immigration status information:** Every person requesting Medi-Cal is required to provide information about his/her citizenship or immigration status. Immigration status information provided as part of the Medi-Cal application is confidential and cannot be used by the INS for immigration enforcement unless you are committing fraud.

**Alien status documents and verification requirements:** Aliens who claim to be in a satisfactory immigration status (SIS) for Medi-Cal purposes must present INS documents that show their immigration status if they have an INS document or are eligible to obtain one. Aliens who claim to be in an SIS, but who cannot obtain an INS document or replacement receipt (for example, aliens in the last PRUCOL category indicated in SECTION B below) should submit other evidence establishing their immigration status. INS documents will be verified by the INS. Aliens who do not have these documents with them, or who have unreadable documents, may bring us receipts which show that they have applied for replacements. Aliens will have 30 days to do this, or until their Medi-Cal application is ruled on, whichever is longer. If the alien is otherwise eligible, Medi-Cal will be issued during this period and while the submitted documentation is being verified by the INS. If none of the documents contains the applicant's photograph, they must show us an identity document which establishes that the applicant is the person named in the documents.

**Social Security number requirement:** Every person requesting Medi-Cal who has a Social Security number is asked to provide it to the county welfare department. U.S. citizens, U.S. nationals, and aliens claiming to be in a satisfactory immigration status who do not have a Social Security number must apply for one and provide it to the county welfare department. Aliens in satisfactory immigration status for Medi-Cal purposes who need help applying for a Social Security number should ask their eligibility worker for assistance. Aliens who are not in a satisfactory immigration status and who do not have a Social Security number can still get restricted Medi-Cal if they meet all eligibility requirements.

**SECTION B: CITIZENSHIP/IMMIGRATION STATUS DECLARATION**

1. Is the applicant a citizen or national of the United States? ☐ Yes ☐ No

If the applicant is a citizen or a national of the United States, where was he/she born? \_\_\_\_\_  
(city, state)

IF YOU ARE A CITIZEN OR NATIONAL OF THE UNITED STATES, GO DIRECTLY TO SECTION D. IF YOU ARE AN ALIEN, PLEASE ANSWER QUESTIONS 2, 3, AND 4 BELOW (AND QUESTION 5 IF YOU CLAIM TO BE PRUCOL) THEN COMPLETE SECTIONS C AND D. IF YOU ANSWER "NO" TO QUESTIONS 2, 3, OR 4 BECAUSE THOSE CATEGORIES DO NOT APPLY TO YOU, YOUR ANSWER IS CONFIDENTIAL. THIS INFORMATION CAN ONLY BE USED FOR MEDI-CAL PURPOSES AND CANNOT BE USED BY THE INS FOR IMMIGRATION ENFORCEMENT UNLESS YOU ARE COMMITTING FRAUD.

2. Is the applicant an amnesty alien with a valid and current I-688? ☐ Yes ☐ No

3. Is the applicant a lawful permanent resident? ☐ Yes ☐ No

4. Is the applicant a PRUCOL alien? ☐ Yes ☐ No

**IMPORTANT: All PRUCOL aliens must indicate their specific PRUCOL status in question 5.**

5. If the applicant would qualify for Medi-Cal benefits as a PRUCOL alien, indicate the status category which entitles him/her to that classification:

☐ A conditional entrant admitted to the United States before April 1, 1980  
☐ An alien paroled into the United States, including Cuban/Haitian entrants

MC 13 (11/99)

- ☐ An alien subject to an Order of Supervision
- ☐ An alien granted an indefinite stay of deportation
- ☐ An alien granted an indefinite voluntary departure
- ☐ An alien on whose behalf an immediate relative petition (INS Form I-130) has been approved and who is entitled to voluntary departure
- ☐ An alien who has properly filed an application for lawful permanent resident status
- ☐ An alien granted a stay of deportation for a specified period
- ☐ An alien granted asylum
- ☐ A refugee admitted to the United States since April 1, 1980
- ☐ An alien granted voluntary departure who is awaiting issuance of a visa
- ☐ An alien in deferred action status
- ☐ An alien who entered and has continuously resided in the United States since before January 1, 1972, who would be eligible for an adjustment of status to lawful permanent resident pursuant to INA Section 249 (eligible as a Registry Alien)
- ☐ An alien granted a suspension of deportation whose departure INS does not contemplate enforcing
- ☐ An alien granted withholding of deportation pursuant to INA Section 243(h)
- ☐ An alien, not in one of the above categories, who can show that: (1) INS knows he/she is in the United States; and (2) INS does not intend to deport him/her, either because of the person's status category or individual circumstances

**SECTION C: VERIFICATION OF IMMIGRATION STATUS (FOR ALIENS WHO CLAIM SATISFACTORY IMMIGRATION STATUS)**

**IMPORTANT:** Complete this section only if you answered "yes" to questions 2, 3, or 4 in SECTION B on the front of this form.

1. Alien Registration number and/or Alien Admission number (INS Form I-94): \_\_\_\_\_
2. Date the applicant first entered the United States: \_\_\_\_\_
3. Applicant's name when he/she first entered the United States: \_\_\_\_\_
4. Of what country is the applicant a citizen: \_\_\_\_\_
5. Where was the applicant born: \_\_\_\_\_

**SECTION D: SOCIAL SECURITY NUMBER**

Does the applicant have a Social Security number (SSN)? (Aliens who are not in a satisfactory immigration status, and who do not have an SSN, can still get restricted Medi-Cal if they meet all eligibility requirements.)

- ☐ Yes, the applicant's Social Security number is: \_\_\_\_\_
- ☐ No

**SECTION E:**

*I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.*

Applicant signature	Date
Signature of person acting for applicant	Date

**FOR COUNTY USE ONLY**

EW number: \_\_\_\_\_ County: \_\_\_\_\_ Date: \_\_\_\_\_

**Action taken:**

- ☐ None necessary.
- ☐ SAVE primary verification performed. Date: \_\_\_\_\_
- ☐ Document Verification Request (INS Form G-845) and copies of documentation of satisfactory immigration status sent to INS. Date: \_\_\_\_\_
- ☐ Full Medi-Cal benefits were granted pending verification of immigration status.
- ☐ Copies of alien status documents are in the case file.
- ☐ Person referred to INS to obtain replacement documents. Date: \_\_\_\_\_


**COUNTY DETERMINATION OF THE APPROPRIATE LEVEL OF MEDI-CAL BENEFITS.**

**Based on the information provided on this form:**

- ☐ The above named applicant is a U.S. citizen or national, or an alien, who, if otherwise eligible, would receive **FULL** Medi-Cal benefits.
- ☐ The above named applicant is an alien, who, if otherwise eligible, would receive **RESTRICTED** Medi-Cal benefits.

## Statement of Facts for Cash Aid, Food Stamps, and Medi-Cal/State-Run County Medical Services Program (SAWS 2)

Online Version: [www.dss.cahwnet.gov/pdf/SAWS2.pdf](http://www.dss.cahwnet.gov/pdf/SAWS2.pdf)

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY				 CALIFORNIA DEPARTMENT OF SOCIAL SERVICES CALIFORNIA DEPARTMENT OF HEALTH SERVICES	
<b>STATEMENT OF FACTS FOR CASH AID, FOOD STAMPS, AND MEDI-CAL/ STATE-RUN COUNTY MEDICAL SERVICES PROGRAM (CMSP)</b>					
<p>● Fill in the answers to all questions about the benefit(s) you are asking for. Print all answers in ink. The "CA" for Cash Aid, "FS" for Food Stamps, and "MC" for Medi-Cal/State CMSP listed to the left of each question tell you which questions are for each program.</p> <p>● Give any proof (such as bills, receipts and records) to support your answers. Tell your worker when you need help in getting proof or in filling out this form. If you need more space, attach another sheet.</p> <p>● If you are asking for Food Stamps and you are not an adult member of the household, attach a written authorization signed by the head of household or other adult member.</p>					
CA FS MC	<b>1 A. Person applying, or caretaker relative of child(ren) for whom aid is wanted.</b> NAME: _____ HOME PHONE: ( ) _____ HOME ADDRESS (NUMBER, STREET) _____ MAILING ADDRESS (IF DIFFERENT) _____ DAYTIME PHONE: ( ) _____ CITY _____ STATE _____ ZIP CODE _____ CITY _____ STATE _____ ZIP CODE _____			<b>COUNTY USE ONLY</b> CASE NAME _____ CASE NUMBER _____ WORKER _____ DATE RCD _____	
FS	<b>B. Are you homeless?</b> If "YES": Are you temporarily staying in someone else's home? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES": Give date you began staying at this home: _____			<input type="checkbox"/> New <input type="checkbox"/> Restoration <input type="checkbox"/> Redetermine <input type="checkbox"/> Recertification <input type="checkbox"/> Residency Verified <input type="checkbox"/> FS ID <input type="checkbox"/> FS Aged/Disabled Verified <input type="checkbox"/> MC ID <input type="checkbox"/> MC Minor Consent: Exempt from ID, Residency, SSN, Verifs	
<b>2 For each ADULT living in the home, give us all the facts.</b>					
CA FS MC	<b>(A) ADULT'S NAME (FIRST, MIDDLE, LAST)</b> _____ CITIZEN/NONCITIZEN STATUS <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> AU <input type="checkbox"/> NON-AU <input type="checkbox"/> MFBU FS Non-HH/Excluded Member Code _____ Work Registration/Exemption Codes: _____ WELFARE to WORK FS ABAWD	
RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) _____ BIRTHDATE (MONTH DAY YEAR) _____ SOCIAL SECURITY NUMBER _____ SEX <input type="checkbox"/> M <input type="checkbox"/> F BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO BIRTHPLACE CITY STATE COUNTRY _____ TYPE OF AID REQUESTED <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Medi-Cal <input type="checkbox"/> State CMSP MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed			VERIFIED <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> SSN <input type="checkbox"/> DED Packet <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE Alien Reg # _____ D.O.E. _____		
CA FS MC	<b>(B) ADULT'S NAME (FIRST, MIDDLE, LAST)</b> _____ CITIZEN/NONCITIZEN STATUS <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> AU <input type="checkbox"/> NON-AU <input type="checkbox"/> MFBU FS Non-HH/Excluded Member Code _____ Work Registration/Exemption Codes: _____ WELFARE to WORK FS ABAWD	
RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) _____ BIRTHDATE (MONTH DAY YEAR) _____ SOCIAL SECURITY NUMBER _____ SEX <input type="checkbox"/> M <input type="checkbox"/> F BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO BIRTHPLACE CITY STATE COUNTRY _____ TYPE OF AID REQUESTED <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Medi-Cal <input type="checkbox"/> State CMSP MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed			VERIFIED <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> SSN <input type="checkbox"/> DED Packet <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE Alien Reg # _____ D.O.E. _____		
CA FS MC	<b>(C) ADULT'S NAME (FIRST, MIDDLE, LAST)</b> _____ CITIZEN/NONCITIZEN STATUS <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> AU <input type="checkbox"/> NON-AU <input type="checkbox"/> MFBU FS Non-HH/Excluded Member Code _____ Work Registration/Exemption Codes: _____ WELFARE to WORK FS ABAWD	
RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) _____ BIRTHDATE (MONTH DAY YEAR) _____ SOCIAL SECURITY NUMBER _____ SEX <input type="checkbox"/> M <input type="checkbox"/> F BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO BIRTHPLACE CITY STATE COUNTRY _____ TYPE OF AID REQUESTED <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Medi-Cal <input type="checkbox"/> State CMSP MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed			VERIFIED <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> SSN <input type="checkbox"/> DED Packet <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE Alien Reg # _____ D.O.E. _____		
<b>COUNTY USE ONLY</b>					
<b>FS NON-HH/EXCLUDED MEMBER (63-402)</b> 1. Separate HH (Purchase/prepare) (12, 13) 2. Separate HH (Elderly/disabled) (17) 3. Roomer (must be listed in (3)) (211) 4. Live-in attendant (212) 5. Other shared living quarters (213) 6. Ineligible alien (221) 7. Boarder (must be listed in (3)) (222) 8. SSN disqualified (222) 9. IPV disqualified (223) 10. Workfare sanctioned (225) 11. SSIS/SP recipient (226) 12. Ineligible student (227) 13. Work req. disqualified (228) 14. Questionable Citizenship (300.51(b)) (408.1, 2) 15. Vol. quit ineligible (410.4) 16. Ineligible/disqualified ABAWD (410.4) 17. Fleeing felon/parole or probation violator (224) 18. Drug/felon (229)		<b>FS WORK/TRAINING EXEMPTIONS (63-407.21)</b> a. Under 16/60 or older a.(1) 16/17 not head of household, or 16/17 in school/training at least 1/2 time b. Mentally/physically unfit for work c. Mandatory participant in Welfare to Work activities d. Cares for child under 6 or incapacitated person e. Applicant for/recipient of UIB f. Participant in drug/alcohol program g. 30 hour week/min. x 30 h. 1/2 time student in school, training or higher education.		<b>FS ABAWD EXEMPTIONS (63-410.3)</b> 1. ABAWD with FS Work/Training Exemption Code 63-407.21 (321) 2. Under 18/50 or older (321) 3. Pregnant (322) 4. Adult living in HH with dep. child (323) 5. Lives in ABAWD exempt area (33)	
<b>WWW WORK EXEMPTIONS (42-712)</b> Age under 16 (41) School Attendance (42) Age 60 or older (43) Disability (44) NCR caring for dependent or ward of the court or at risk of FC placement (45) Care of another ill or incapacitated member of the household (46) Care of child: - Age 6 months or under (or as allowed under county's CalWORKs plan) (471) - Member (who previously claimed 471) upon birth or adoption of subsequent child(ren) (472) Pregnancy (48) VISTA-full or part time volunteer (49)					
SAWS 2 (6/02) CA 20FA 265-A21MC 210 REQUIRED FORM—SUBSTITUTE PERMITTED Page 1 of 14					

③ For each **CHILD** living in the home, child out of the home for a short time, or child you claim as a tax dependent, give us all the facts. If you are pregnant, list child as "unborn" and give due date.

## COUNTY USE ONLY

<b>CA</b> (A) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. CITIZEN/NATIONAL		CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)		AU (✓) <input type="checkbox"/> NON-AU (✓) <input type="checkbox"/> MFB (✓) <input type="checkbox"/> MFG CHILD <input type="checkbox"/> FS Non-HH/Excluded Member Code:	
SOCIAL SECURITY NUMBER		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F BIRTHDATE OR DUE DATE (Month, Day, Year)		AGE OF CHILD		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MC: not in home, 18-21 & tax dep.	
BIRTHPLACE (CITY/STATE/COUNTRY)		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		ARE IMMUNIZATIONS UP TO DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO		BLIND, DEAF OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, NAME OF SCHOOL:		DEATH <input type="checkbox"/> DISABILITY <input type="checkbox"/> ABSENCE <input type="checkbox"/> UNEMPLOYMENT <input type="checkbox"/>		CW 2.1 <input type="checkbox"/> CW 3.7 <input type="checkbox"/> Allen Reg. # <input type="checkbox"/> D.O.E. <input type="checkbox"/>	
TYPE OF AID REQUESTED <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medi-Cal <input type="checkbox"/> None		MOTHER'S NAME				Work Registration/Exemption Codes:	
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME		Welfare-to-Work <input type="checkbox"/> FS <input type="checkbox"/>	
						Verified: <input type="checkbox"/> Age <input type="checkbox"/> Deprivation <input type="checkbox"/> SSN	
						<input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> DED Packet	
						<input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE	
						<input type="checkbox"/> Immunization <input type="checkbox"/> School Attendance	

<b>CA</b> (B) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. CITIZEN/NATIONAL		CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)		AU (✓) <input type="checkbox"/> NON-AU (✓) <input type="checkbox"/> MFB (✓) <input type="checkbox"/> MFG CHILD <input type="checkbox"/> FS Non-HH/Excluded Member Code:	
SOCIAL SECURITY NUMBER		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F BIRTHDATE OR DUE DATE (Month, Day, Year)		AGE OF CHILD		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MC: not in home, 18-21 & tax dep.	
BIRTHPLACE (CITY/STATE/COUNTRY)		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		ARE IMMUNIZATIONS UP TO DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO		BLIND, DEAF OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, NAME OF SCHOOL:		DEATH <input type="checkbox"/> DISABILITY <input type="checkbox"/> ABSENCE <input type="checkbox"/> UNEMPLOYMENT <input type="checkbox"/>		CW 2.1 <input type="checkbox"/> CW 3.7 <input type="checkbox"/> Allen Reg. # <input type="checkbox"/> D.O.E. <input type="checkbox"/>	
TYPE OF AID REQUESTED <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medi-Cal <input type="checkbox"/> None		MOTHER'S NAME				Work Registration/Exemption Codes:	
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME		Welfare-to-Work <input type="checkbox"/> FS <input type="checkbox"/>	
						Verified: <input type="checkbox"/> Age <input type="checkbox"/> Deprivation <input type="checkbox"/> SSN	
						<input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> DED Packet	
						<input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE	
						<input type="checkbox"/> Immunization <input type="checkbox"/> School Attendance	

<b>CA</b> (C) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. CITIZEN/NATIONAL		CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)		AU (✓) <input type="checkbox"/> NON-AU (✓) <input type="checkbox"/> MFB (✓) <input type="checkbox"/> MFG CHILD <input type="checkbox"/> FS Non-HH/Excluded Member Code:	
SOCIAL SECURITY NUMBER		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F BIRTHDATE OR DUE DATE (Month, Day, Year)		AGE OF CHILD		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MC: not in home, 18-21 & tax dep.	
BIRTHPLACE (CITY/STATE/COUNTRY)		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		ARE IMMUNIZATIONS UP TO DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO		BLIND, DEAF OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, NAME OF SCHOOL:		DEATH <input type="checkbox"/> DISABILITY <input type="checkbox"/> ABSENCE <input type="checkbox"/> UNEMPLOYMENT <input type="checkbox"/>		CW 2.1 <input type="checkbox"/> CW 3.7 <input type="checkbox"/> Allen Reg. # <input type="checkbox"/> D.O.E. <input type="checkbox"/>	
TYPE OF AID REQUESTED <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medi-Cal <input type="checkbox"/> None		MOTHER'S NAME				Work Registration/Exemption Codes:	
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME		Welfare-to-Work <input type="checkbox"/> FS <input type="checkbox"/>	
						Verified: <input type="checkbox"/> Age <input type="checkbox"/> Deprivation <input type="checkbox"/> SSN	
						<input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> DED Packet	
						<input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE	
						<input type="checkbox"/> Immunization <input type="checkbox"/> School Attendance	

<b>CA</b> (D) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. CITIZEN/NATIONAL		CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)		AU (✓) <input type="checkbox"/> NON-AU (✓) <input type="checkbox"/> MFB (✓) <input type="checkbox"/> MFG CHILD <input type="checkbox"/> FS Non-HH/Excluded Member Code:	
SOCIAL SECURITY NUMBER		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F BIRTHDATE OR DUE DATE (Month, Day, Year)		AGE OF CHILD		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MC: not in home, 18-21 & tax dep.	
BIRTHPLACE (CITY/STATE/COUNTRY)		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO		ARE IMMUNIZATIONS UP TO DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO		BLIND, DEAF OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, NAME OF SCHOOL:		DEATH <input type="checkbox"/> DISABILITY <input type="checkbox"/> ABSENCE <input type="checkbox"/> UNEMPLOYMENT <input type="checkbox"/>		CW 2.1 <input type="checkbox"/> CW 3.7 <input type="checkbox"/> Allen Reg. # <input type="checkbox"/> D.O.E. <input type="checkbox"/>	
TYPE OF AID REQUESTED <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medi-Cal <input type="checkbox"/> None		MOTHER'S NAME				Work Registration/Exemption Codes:	
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME		Welfare-to-Work <input type="checkbox"/> FS <input type="checkbox"/>	
						Verified: <input type="checkbox"/> Age <input type="checkbox"/> Deprivation <input type="checkbox"/> SSN	
						<input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> DED Packet	
						<input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE	
						<input type="checkbox"/> Immunization <input type="checkbox"/> School Attendance	

<b>CA ④ List any parent(s) of the child(ren) or unborn who does not live in the home with you.</b>				<b>COUNTY USE ONLY</b>	
NAME OF PARENT		REASON THE PARENT DOES NOT LIVE IN THE HOME		<input type="checkbox"/> Verif. on File <input type="checkbox"/> MC 13	
<b>CA ⑤ FS Has anyone changed citizenship/immigration status in the last 12 months?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:					
NAME		WHAT CHANGED	DATE	ALIEN NUMBER (IF APPLICABLE)	
<b>CA ⑥ A. Is a foster child living in the home?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", who:				<input type="checkbox"/> CA and FC Elig/CR Chooses: Child: <input type="checkbox"/> CA <input type="checkbox"/> FC CR: <input type="checkbox"/> CA <input type="checkbox"/> None <input type="checkbox"/> Kin-GAP	
<b>FS B. Do you want the foster child(ren) and foster care income counted on the Food Stamp Case?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO					
<b>CA ⑦ FS Has anyone ever used any other name (maiden, adoptive, etc.)?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:					
NAME		OTHER NAME(S) USED			
NAME		OTHER NAME(S) USED			
				YES	NO
<b>CA ⑧ A. Does everyone live in California?</b> If "NO", explain:					
<b>CA B. Does everyone plan to stay in California permanently?</b>					
<b>CA C. Does anyone own, lease or maintain a home outside California?</b>					
<b>CA ⑧ MC D. Is anyone currently getting public assistance outside California?</b> If "YES", explain:					
<b>CA E. Is anyone planning to leave California for more than 30 days?</b>					
<b>MC ⑨ Are you 18 to 21 years of age and claimed as a dependent for income tax purposes?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, who:				<input type="checkbox"/> Calif. Resident: <input type="checkbox"/> YES <input type="checkbox"/> NO  <input type="checkbox"/> Property <input type="checkbox"/> PA	
<b>CA ⑩ A. Has anyone's cash aid or food stamps been stopped due to:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO non-cooperation during a quality control review, work or training sanctions or failure to meet the Food Stamp Able Bodied Adults Without Dependent (ABAWD) work requirement, or for any other reason? If "YES", explain below:					
NAME	WHY	WHEN	WHAT COUNTY/STATE		
<b>CA ⑩ FS B. Has anyone's cash aid or food stamps been stopped for a period of time or forever due to welfare fraud or a food stamp intentional Program Violation?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain below:					
NAME	WHY	WHEN	WHAT COUNTY/STATE		
<b>FS ⑪ Does anyone living with you buy food and fix meals separately from others in the home?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", who:				Separate household eligible: <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>FS ⑫ Is anyone living with you age 60 or older and unable to buy food and fix meals separately because of a disability?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", who:				Separate household eligible: <input type="checkbox"/> YES <input type="checkbox"/> NO	

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<b>FS 13 A. Do you pay someone else for meals and/or a room?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						COUNTY USE ONLY			
NAME OF PERSON YOU PAY		CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both		HOW MUCH \$	HOW OFTEN	NO. OF MEALS PER DAY	Household Elects		ROOMER
							BOARDER	HH MEMBER	
<b>CA FS 13 B. Does anyone pay you for meals and/or a room?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:									
NAME OF PERSON WHO PAYS YOU		CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both		HOW MUCH \$	HOW OFTEN	NO. OF MEALS PER DAY			
<b>FS 14 Does anyone get food from any of the following programs?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <ul style="list-style-type: none"> <li>• Communal dining facility for the elderly or disabled</li> <li>• Food distribution program operated by a Native American reservation</li> <li>• Other food program</li> </ul>									
NAME	NAME OF PROGRAM	NAME	NAME OF PROGRAM						
<b>CA FS MC 15 A. Does anyone live in any of the following:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						<b>FS Eligible Institution:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO  <b>CA Eligible:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME		NAME OF CENTER, SHELTER, HOSPITAL, ETC.		DATE ENTERED	DATE EXPECTED TO LEAVE				
<b>MC B. Does the person who is in a hospital or nursing home have a spouse or other family member at home?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO									
<b>CA 16 List any child age 6-16 who does not attend school regularly and explain why he/she is not attending regularly.</b> <input type="checkbox"/> No Child Age 6-16						<b>School Attendance Verified:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME	REASON NOT ATTENDING SCHOOL REGULARLY								
<b>CA FS MC 17 A. Is anyone age 14 or older enrolled in school, college, or a training program? If "YES", complete below:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO						<b>School Enrollment Verif.:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO  <b>Date Verified:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>FS Eligible Student:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME	AGE	NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	ENROLLED (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):	UNITS/HOURS PER WEEK	WORKING <input type="checkbox"/> YES <input type="checkbox"/> NO				
NAME	AGE	NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM	ENROLLED (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):	UNITS/HOURS PER WEEK	WORKING <input type="checkbox"/> YES <input type="checkbox"/> NO				
<b>CA FS B. Complete below for anyone enrolled in college or attending a similar educational institution.</b>						<b>Expenses Verified:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO  <b>Date Verified:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO  <b>Financial Aid:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MC 210 S-E			
NAME	TERM (✓) CHECK STATUS <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter	TUITION/FEES PER TERM \$	BOOKS, EQUIPMENT, ETC., PER TERM \$						
MILES ROUND-TRIP PER DAY TO SCHOOL/CHILD CARE		DAYS ATTENDING PER WEEK	TRANSPORTATION USED						
TRANSPORTATION COST PER WEEK \$		AMOUNT PAID PER WEEK BY CAR POOL MEMBERS \$	PUBLIC TRANSPORTATION (BUS, ETC.) PER DAY \$						
<b>CA 18 A. Is anyone under age 20 and pregnant or a parent?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						<b>Referred to:</b> <input type="checkbox"/> Cal-Learn <input type="checkbox"/> CW 25 <input type="checkbox"/> CW 25A <input type="checkbox"/> Referred to Welfare-to-Work			
NAME	AGE	CHECK (✓) STATUS <input type="checkbox"/> Pregnant <input type="checkbox"/> Teen Parent							
SCHOOL STATUS, CHECK (✓) <input type="checkbox"/> Has a High School Diploma <input type="checkbox"/> Has a GED <input type="checkbox"/> Not Attending School Regularly (explain): <input type="checkbox"/> Currently Attending School Regularly <input type="checkbox"/> Other (explain):									
<b>B. Has anyone received a cash bonus or penalty, or help with child care, transportation, etc. from the Cal-Learn Program?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:									
NAME	WHERE (COUNTY)	DATE(S) RECEIVED							
<b>CA FS 19 Is anyone on strike?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						<b>Striker Regs Apply:</b> <input type="checkbox"/> CA <input type="checkbox"/> FS			
NAME OF STRIKER		NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM							
NAME OF UNION									
DATE WENT ON STRIKE		MONTHLY INCOME (BEFORE DEDUCTIONS) EARNED FROM THIS JOB BEFORE THE STRIKE \$							

CA FS MC	20	<b>Has anyone, including children, worked or does anyone expect to go to work, including part-time and occasional work? Check (✓) "YES" or "NO" for each item.</b> If "YES", complete below:	YES	NO	<b>COUNTY USE ONLY</b>
		Has anyone stopped or refused work or training within the last 60 days?			(A) (✓) if exempt FS S/E Farmer CA MC <input type="checkbox"/> FS Adult <input type="checkbox"/> Yes <input type="checkbox"/> No
		Is anyone working or in training now?			<input type="checkbox"/> FS Child
		Does anyone expect to be working or in training in the next two months?			(B) (✓) if exempt FS S/E Farmer CA MC <input type="checkbox"/> FS Adult <input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> FS Child
If self-employed: <b>For Food Stamps:</b> List your business expenses on a separate sheet of paper. <b>For Cash Aid:</b> Check (✓) how you want your business expenses figured each month: <input type="checkbox"/> 40% standard deduction <input type="checkbox"/> Actual business expenses <input type="checkbox"/> Monthly average (yearly business costs divided by 12 months) <b>If actual</b> , you must list your business expenses on a separate sheet of paper.					
(A) NAME CA FS MC		NUMBER OF HOURS OF WORK/TRAINING PER MONTH LAST MONTH _____ THIS MONTH _____		EMPLOYER'S NAME AND ADDRESS _____	
PAY DATE(S) _____		SELF-EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO		WAGES BEFORE DEDUCTIONS \$ _____ per _____	
		DATE LAST CHECK RECEIVED _____		RECEIVED OR EXPECT TO RECEIVE TIPS OR COMMISSIONS <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", COMPLETE BELOW	
REASON FOR LEAVING JOB/TRAINING _____		LAST DAY OF WORK/TRAINING _____		AMOUNT RECEIVED \$ _____ AMOUNT EXPECTED \$ _____	
DATE NEXT CHECK EXPECTED _____		AMOUNT EXPECTED BEFORE DEDUCTIONS \$ _____		OCCUPATION _____	
(B) NAME CA FS MC		NUMBER OF HOURS OF WORK/TRAINING PER MONTH LAST MONTH _____ THIS MONTH _____		EMPLOYER NAME AND ADDRESS _____	
PAY DATE(S) _____		SELF-EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO		WAGES BEFORE DEDUCTIONS \$ _____ per _____	
		DATE LAST CHECK RECEIVED _____		RECEIVED OR EXPECT TO RECEIVE TIPS OR COMMISSIONS <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", COMPLETE BELOW	
REASON FOR LEAVING JOB/TRAINING _____		LAST DAY OF WORK/TRAINING _____		AMOUNT RECEIVED \$ _____ AMOUNT EXPECTED \$ _____	
DATE NEXT CHECK EXPECTED _____		AMOUNT EXPECTED BEFORE DEDUCTIONS \$ _____		OCCUPATION _____	
(A) <input type="checkbox"/> CA: 28 Days (B) <input type="checkbox"/> CA: 28 Days <input type="checkbox"/> FS: 60 days <input type="checkbox"/> FS: 60 days <input type="checkbox"/> MC: 30 days <input type="checkbox"/> MC: 30 days (B) _____ YES NO Empl. Statement _____ Good Cause Determination _____ Voluntary Quit _____ CA: S/E Client Chooses: (A) _____ (B) _____ <input type="checkbox"/> Actual <input type="checkbox"/> Actual <input type="checkbox"/> 40% deduction <input type="checkbox"/> 40% deduction <input type="checkbox"/> Annualize <input type="checkbox"/> Annualize Child Care Informing: <input type="checkbox"/> Trustline Informing (CCP 2) <input type="checkbox"/> Health & Safety Certification (CCP 5) <input type="checkbox"/> Dependent Care Verified DEP. CARE ELIGIBLE YES NO FS _____ MC _____ Is there another person in household who could provide care? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", who: _____ Court Order on File <input type="checkbox"/> YES <input type="checkbox"/> NO Amount Ordered: \$ _____					
CA FS MC	21	<b>A. Does anyone pay for care of a child, disabled adult, or other dependent so he/she can go to work, school, or look for a job? If "YES", complete below and (✓) if for work or training.</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			
WHO GETS CARE		WHO PAYS		WHO GIVES CARE	AMOUNT PAID/HOW OFTEN
				<input type="checkbox"/> WORK <input type="checkbox"/> TRAINING	\$ _____ EVERY _____
WHO GETS CARE		WHO PAYS		WHO GIVES CARE	AMOUNT PAID/HOW OFTEN
				<input type="checkbox"/> WORK <input type="checkbox"/> TRAINING	\$ _____ EVERY _____
CA FS MC	B.	<b>Does anyone else pay all or part of your child care costs? Include costs paid by a relative or friend not living in the home, Department of Education, Block Grant, etc. If "YES", complete below:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME OF CHILD		WHO PAYS		MONTHLY AMOUNT PAID	WHO ELSE PAYS
				\$ _____	\$ _____
NAME OF CHILD		WHO PAYS		MONTHLY AMOUNT PAID	WHO ELSE PAYS
				\$ _____	\$ _____
FS MC	22	<b>Does anyone pay child or spousal support? If "YES", complete below:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			
WHO PAYS		FOR WHOM		AMOUNT PER MONTH	
				\$ _____	
CA FS MC	23	<b>Has anyone, including children, applied for or received unemployment or disability insurance benefits in the last 12 months OR expect to receive these benefits in the future? If "YES", complete below:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME		DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED	
NAME		DATE APPLIED	WHERE (COUNTY/STATE)	DATE LAST RECEIVED	
CA	24	<b>Has anyone received a Diversion cash payment or non-cash services from any county or other state? If "YES", complete below:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME		COUNTY/STATE	AMOUNT RECEIVED	LIST SERVICES RECEIVED	ESTIMATED VALUE OF SERVICES
			\$ _____		\$ _____

Employment History						Page 6 of 14	
<b>CA 26</b> <b>Has any parent living in the home worked or been in training in the past 24 months?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>FS</b> If "YES", complete below: • Include all work done in and outside the United States (U.S.). • Include work done in exchange for something besides money, such as rent, food, utilities or <u>anything else</u> . • Begin with each person's most recent job or training.						<b>COUNTY USE ONLY</b>  <i>PE/USB Requirements</i> <i>Earnings from month prior to month of application</i> App Date: _____ Earnings from _____ to _____ MO/YR <b>25</b> A <b>25</b> B	
<b>A. NAME</b> _____			<b>IS HE/SHE A NATIVE AMERICAN?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", LIST TRIBE: _____				
Name and Address of Employer or Training Program <b>(✓)</b> Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid \$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Name and Address of Employer or Training Program <b>(✓)</b> Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid \$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
1. <input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	4. <input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
2. <input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	5. <input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
3. <input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	6. <input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
<b>B. NAME</b> _____			<b>IS HE/SHE A NATIVE AMERICAN?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", LIST TRIBE: _____				
Name and Address of Employer or Training Program <b>(✓)</b> Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid \$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Name and Address of Employer or Training Program <b>(✓)</b> Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid \$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
1. <input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	4. <input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
2. <input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	5. <input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
3. <input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	6. <input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
<b>FS 26</b> <b>Are all Food Stamp household members citizens of the United States (U.S.)?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO If "NO", complete below for each Food Stamp household member who is <u>not a citizen of the U.S.</u>							
Name of each noncitizen	<b>A.</b> How many years total has this person, their spouse, and/or their parents (before this person was 18 years old) lived in the U.S.?	<b>B.</b> While living in the U.S., in how many of the years reported in Column A did this person, their spouse, and/or their parents (before this person was 18 years old) earn money by working in the U.S.?	<b>C.</b> While living outside the U.S., how many total years did this person, their spouse, and/or their parents (before this person was 18 years old) work in the U.S.?				
1.							
2.							
3.							
4.							
				TOTAL \$ _____ \$ _____			
				<b>25</b> A B			
				Tribal JOBS Referral			
				UIB Verif(s) on file			
				Must apply for UIB			
<b>CA 27</b> <b>Has anyone been in the U.S. military service or the spouse, parent, or child of a person who has been in the military service?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>FS MC</b> If "YES", complete below:							
NAME	U.S. CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>(✓) STATUS</b> <input type="checkbox"/> ACTIVE DUTY MILITARY/VETERAN <input type="checkbox"/> SPOUSE, PARENT OR CHILD OF ACTIVE DUTY MILITARY/VETERAN	HONORABLE DISCHARGE <input type="checkbox"/> YES <input type="checkbox"/> NO	BRANCH OF SERVICE	DATE OF SERVICE		
NAME	U.S. CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO	(✓) STATUS <input type="checkbox"/> ACTIVE DUTY MILITARY/VETERAN <input type="checkbox"/> SPOUSE, PARENT OR CHILD OF ACTIVE DUTY MILITARY/VETERAN	HONORABLE DISCHARGE <input type="checkbox"/> YES <input type="checkbox"/> NO	BRANCH OF SERVICE	DATE OF SERVICE		
<b>COUNTY USE ONLY</b>							
PRINCIPAL EARNER (PE) *				DATE OF APPLICATION		QUARTER OF APPLICATION	
*Principal Earner — the parent who earned the most income in the last 24 months prior to the month of application.							
						<b>26</b> FS: <input type="checkbox"/> 40 Quarters Verif.  <b>27</b> <input type="checkbox"/> CW 5 FS: Noncitizen's Honorable Discharge Verif. <input type="checkbox"/> YES <input type="checkbox"/> NO	

<b>CA 28 A. Does anyone, including children, get or expect to get money from any source listed below?</b> FS Check (✓) "YES" or "NO" for each item. MC						<b>COUNTY USE ONLY</b>		
	YES	NO		YES	NO	<input type="checkbox"/> Casualty Unit Notified <input type="checkbox"/> CWC 6041 <input type="checkbox"/> DHS 6155 <input type="checkbox"/> Verif(s) on File Explain Anticip. Income Workers Comp: <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent		
Work Study, JTPA, Welfare-to-Work, or other program			VA (Veterans) educational related income					
Other training allowance			VA Aid & Attendance					
Educational grants, loans and scholarships			Social Security disability or supplemental security income/state supplementary payment (SSI/SSP)					
CalWORKs/Cash aid from another state			VA disability					
Refugee (RCA) Assistance			Railroad disability					
Cash Assistance Program for Immigrants (CAPI)			Other disability income from a federal, state, or local governmental agency					
GAAGR (General Assistance/Relief)			Other non-government disability or sick leave					
Workers Compensation			Social Security retirement or survivors					
Child/spousal support or money for medical bills or premiums			Railroad retirement					
Strike benefits			Other retirement income from a federal, state, or local governmental agency					
Loans, gifts, contributions			Other non-government retirement income					
Legal or insurance settlements/ court actions pending			Per capita payments					
Sales of notes, contracts, trust deeds, promissory notes			Winnings (gambling/lottery/bingo, prizes, etc.)					
Military allotment or pension			Other (Explain)					
If "YES", complete below:						(✓) if exempt		
NAME	SOURCE		(AMOUNT RECEIVED BEFORE DEDUCTIONS)	WHEN	HOW OFTEN	CA	FS	MC
			\$					
			\$					
<b>CA B. Does anyone expect a change in the amount of money received now, such as a cost-of-living raise?</b> FS If "YES", complete below: MC						<input type="checkbox"/> YES <input type="checkbox"/> NO		
NAME	WHAT	AMOUNT	WHEN					
		\$						
<b>CA 29 Does anyone get housing or rent, utilities, food or clothing free or in exchange for work?</b> FS If "YES", complete below and check (✓) if free or in exchange for work: MC						<input type="checkbox"/> YES <input type="checkbox"/> NO		
ITEM RECEIVED	Free	For Work	WHO RECEIVES THE ITEM	VALUE	WHO PROVIDES THE ITEM	In-Kind Income: Verif. on file: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Housing or rent				\$		Partial	Full	Earned Unearned
Utilities				\$				
Food				\$				
Clothing				\$				
<b>CA 30 A. Does anyone own or is anyone buying real estate, such as land and/or buildings anywhere, including outside the U.S.?</b> FS If "YES", complete below. Include land and/or buildings in which the title is shared. MC						<input type="checkbox"/> YES <input type="checkbox"/> NO		
TYPE (LAND, CONDO, APARTMENT, HOUSE)	HOW DO YOU USE THIS PROPERTY? CHECK (✓)	YES	NO	OWNER(S)	ADDRESS OR LOCATION	AMOUNT OWED	RENTAL INCOME	Home Exempt Other Real Property Market Value Amount Owed Net Value Lien Applicable Listed for sale
	LIVE IN IT					\$	\$	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
LISTED FOR SALE	RENTAL PROPERTY							
<input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER (EXPLAIN)							
TYPE (LAND, CONDO, APARTMENT, HOUSE)	HOW DO YOU USE THIS PROPERTY? CHECK (✓)	YES	NO	OWNER(S)	ADDRESS OR LOCATION	AMOUNT OWED	RENTAL INCOME	Home Exempt Other Real Property Market Value Amount Owed Net Value Lien Applicable Listed for sale
	LIVE IN IT					\$	\$	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
LISTED FOR SALE	RENTAL PROPERTY							
<input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER (EXPLAIN)							
<b>CA B. Does anyone own a house that is not lived in now that he/she hopes to return to someday?</b> FS If "YES", complete below: MC						<input type="checkbox"/> YES <input type="checkbox"/> NO		
OWNER OF PROPERTY		PROPERTY ADDRESS			EXPECTED DATE OF RETURN (IF KNOWN)	CA	\$	
						FS	\$	
						MC	\$	

<b>CA</b> <b>FS</b> <b>MC</b>	<p><b>31 A. Does anyone, including children, have any of the following personal or business-related resources?</b> Check (✓) each item either "YES" or "NO".  <small>Include all resources owned, used, controlled, shared or held jointly with any person(s) (even for convenience only). The county will determine whether or not these resources count.</small></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 5%;">YES</th> <th style="width: 5%;">NO</th> <th style="width: 60%;"></th> <th style="width: 5%;">YES</th> <th style="width: 5%;">NO</th> </tr> </thead> <tbody> <tr> <td>Cash (on hand or elsewhere)</td> <td></td> <td></td> <td>Trust funds (whether or not available)</td> <td></td> <td></td> </tr> <tr> <td>Uncashed checks (on hand or elsewhere)</td> <td></td> <td></td> <td>Notes, mortgages, deeds of trust, contracts of sale, etc.</td> <td></td> <td></td> </tr> <tr> <td>Savings accounts - children's and adult's</td> <td></td> <td></td> <td>IRA or Keogh plans, etc.</td> <td></td> <td></td> </tr> <tr> <td>Checking accounts - whether or not they are used</td> <td></td> <td></td> <td>Retirement funds which are available if you stop work (such as PERS, etc.)</td> <td></td> <td></td> </tr> <tr> <td>Credit union accounts</td> <td></td> <td></td> <td>Employee deferred compensation plans</td> <td></td> <td></td> </tr> <tr> <td>Stocks, bonds, certificates of deposit, money market accounts, etc.</td> <td></td> <td></td> <td>Life insurance or annuity</td> <td></td> <td></td> </tr> <tr> <td>Oil, mining, or mineral rights</td> <td></td> <td></td> <td>Life estate interest in any property</td> <td></td> <td></td> </tr> <tr> <td>Burial trusts or contracts, insurance, designated burial funds/money for cemetery plots, caskets, or other burial items</td> <td></td> <td></td> <td>Long term care insurance</td> <td></td> <td></td> </tr> <tr> <td>Income tax refund</td> <td></td> <td></td> <td>EBT cash balance from a previous month</td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>Other (explain)</td> <td></td> <td></td> </tr> </tbody> </table> <p style="text-align: center;"><b>IF "YES", COMPLETE BELOW:</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">RESOURCE</th> <th style="width: 10%;">BUSINESS-RELATED</th> <th style="width: 15%;">OWNER</th> <th style="width: 15%;">ACCOUNT/POLICY NO.</th> <th style="width: 20%;">NAME AND ADDRESS OF BANK, ETC.</th> <th style="width: 15%;">CURRENT VALUE</th> </tr> </thead> <tbody> <tr> <td></td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td></td> <td></td> <td></td> <td>\$</td> </tr> <tr> <td></td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td></td> <td></td> <td></td> <td>\$</td> </tr> <tr> <td></td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td></td> <td></td> <td></td> <td>\$</td> </tr> </tbody> </table> <p><b>32 B. Does anyone get or expect to get money from any of the above resources, such as interest, dividends, etc.?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO  <small>If "YES", complete below:</small></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">NAME</th> <th style="width: 20%;">SOURCE OF MONEY</th> <th style="width: 10%;">AMOUNT</th> <th style="width: 10%;">HOW OFTEN</th> <th style="width: 40%;">BUSINESS-RELATED</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td>\$</td> <td></td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> <tr> <td></td> <td></td> <td>\$</td> <td></td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> </tr> </tbody> </table> <p><b>MC 32 Are there any liens recorded or did you sign a security agreement with a doctor, clinic, or hospital against any property owned by you or any family member that is used as security for health care services?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO  <small>If "YES", complete below:</small></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">LIEN OR SECURED AMOUNT</th> <th style="width: 30%;">TYPE AND LOCATION OF PROPERTY</th> <th style="width: 20%;">DATE AND TYPE OF MEDICAL CARE RECEIVED/TO BE RECEIVED</th> <th style="width: 35%;">NAME OF PROVIDER</th> </tr> </thead> <tbody> <tr> <td>\$</td> <td></td> <td></td> <td></td> </tr> <tr> <td>\$</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p><b>MC 33 A. Does anyone own any personal property, such as:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO  <ul style="list-style-type: none"> <li>• Non-motorboats, camper shells, non-motor trailers.</li> <li>• Guns, tools, or sporting equipment, etc.</li> <li>• Pets or livestock for personal use.</li> <li>• Jewelry, artwork, antiques, collections, cameras, musical equipment (pianos, guitars, amplifiers, etc.).</li> </ul> <small>If "YES", complete below: Do not include wedding and engagement rings or heirlooms. List jewelry worth more than \$100 and household goods or personal items worth more than \$500 per item.</small></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">ITEM</th> <th style="width: 10%;">LISTED FOR SALE</th> <th style="width: 15%;">PURCHASE PRICE OR CURRENT VALUE</th> <th style="width: 10%;">AMOUNT OWED</th> <th style="width: 10%;">ITEM</th> <th style="width: 10%;">LISTED FOR SALE</th> <th style="width: 15%;">PURCHASE PRICE OR CURRENT VALUE</th> <th style="width: 10%;">AMOUNT OWED</th> </tr> </thead> <tbody> <tr> <td></td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>\$</td> <td>\$</td> <td></td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>\$</td> <td>\$</td> </tr> <tr> <td></td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>\$</td> <td>\$</td> <td></td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>\$</td> <td>\$</td> </tr> </tbody> </table> <p><b>MC B. Does anyone have any business property, including tools, inventory and materials, business equipment, livestock, etc.?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO  <small>Include any property that is shared or held jointly with any other person(s). If "YES", complete below:</small></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">ITEM</th> <th style="width: 10%;">LISTED FOR SALE</th> <th style="width: 15%;">PURCHASE PRICE OR CURRENT VALUE</th> <th style="width: 10%;">AMOUNT OWED</th> <th style="width: 10%;">ITEM</th> <th style="width: 10%;">LISTED FOR SALE</th> <th style="width: 15%;">PURCHASE PRICE OR CURRENT VALUE</th> <th style="width: 10%;">AMOUNT OWED</th> </tr> </thead> <tbody> <tr> <td></td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>\$</td> <td>\$</td> <td></td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>\$</td> <td>\$</td> </tr> <tr> <td></td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>\$</td> <td>\$</td> <td></td> <td><input type="checkbox"/> YES <input type="checkbox"/> NO</td> <td>\$</td> <td>\$</td> </tr> </tbody> </table>		YES	NO		YES	NO	Cash (on hand or elsewhere)			Trust funds (whether or not available)			Uncashed checks (on hand or elsewhere)			Notes, mortgages, deeds of trust, contracts of sale, etc.			Savings accounts - children's and adult's			IRA or Keogh plans, etc.			Checking accounts - whether or not they are used			Retirement funds which are available if you stop work (such as PERS, etc.)			Credit union accounts			Employee deferred compensation plans			Stocks, bonds, certificates of deposit, money market accounts, etc.			Life insurance or annuity			Oil, mining, or mineral rights			Life estate interest in any property			Burial trusts or contracts, insurance, designated burial funds/money for cemetery plots, caskets, or other burial items			Long term care insurance			Income tax refund			EBT cash balance from a previous month						Other (explain)			RESOURCE	BUSINESS-RELATED	OWNER	ACCOUNT/POLICY NO.	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CA FS MC	34	Has anyone sold, spent, traded, transferred, or given away any real property, such as a house or land; or personal property such as money, cars, bank accounts, money from a legal or accident insurance settlement, or anything else? (List any property sold or traded within the last 12 months for cash aid, 3 months for food stamps, and within the last 2 1/2 years (30 months) for Medi-Cal). If "YES", explain what and when:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>COUNTY USE ONLY</b>																																																																
				Transfer of Assets: <input type="checkbox"/> CA in last 12 months <input type="checkbox"/> FS in last 3 months <input type="checkbox"/> Medi-Cal in last 30 months LTC ONLY <input type="checkbox"/> Adequate Consideration <input type="checkbox"/> Spenddown Total Nonexempt Property \$																																																																
CA FS MC	35	Does anyone own, have the use of or have their name on the registration of any motor vehicle, such as: automobile, motorcycle, snowmobile, recreational vehicle, motorboat, etc., even if not running? If "YES", complete below. Look at your registration to get facts for each vehicle:	<input type="checkbox"/> YES <input type="checkbox"/> NO																																																																	
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<b>CA FS 36 A. Does anyone have any housing costs?</b> <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> If "YES", complete below:					<b>COUNTY USE ONLY</b>	
HOUSING COSTS	TOTAL COST	HOW MUCH YOU PAY	HOW MUCH OTHER FAMILY/ HOUSEHOLD MEMBERS PAY	HOW OFTEN BILLED	Housing verified: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Rent	\$	\$	\$		Total housing: \$ _____	
House (mortgage) payment	\$	\$	\$		Shared housing: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Property taxes (if not in house payment)	\$	\$	\$			
Insurance (if not in house payment)	\$	\$	\$			
Other (explain)	\$	\$	\$			
<b>CA FS B. Does anyone else pay all or part of these housing costs? Include a relative or friend not living in the home, any rental assistance programs, such as HUD, Section 8, etc. If "YES", complete below:</b> <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>						
TYPE OF HOUSING COST	NAME OF PERSON WHO PAYS	HOW MUCH EACH PAYS	HOW OFTEN BILLED			
		\$				
		\$				
<b>FS 37 A. Does anyone have any utility costs?</b> <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> If "YES", complete below:						
UTILITY COSTS	TOTAL COST	HOW MUCH YOU PAY	HOW MUCH OTHER FAMILY/ HOUSEHOLD MEMBERS PAY	HOW OFTEN BILLED	Utilities verified: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Gas or other fuel	\$	\$	\$		Metered: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Electricity or other fuel	\$	\$	\$		Client elects <input type="checkbox"/> Actual	
Is the gas or electricity or other fuel used to heat or cool your house?	<input type="checkbox"/> YES <input type="checkbox"/> NO				If Actual, Total Utilities \$ _____	
Water	\$	\$	\$		<input type="checkbox"/> SUA	
Sewer	\$	\$	\$		SUA prorated: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Garbage or trash	\$	\$	\$			
Telephone (basic rate for one phone plus tax)	\$	\$	\$			
Installation of utilities	\$	\$	\$			
Other (explain)	\$	\$	\$			
<b>FS B. Does anyone else pay all or part of these utility costs? Include a relative/friend not living in the home, Low Income Energy Assistance, etc. If "YES", complete below:</b> <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>						
TYPE OF UTILITY COST	NAME OF PERSON WHO PAYS	HOW MUCH EACH PAYS	HOW OFTEN BILLED			
		\$				
		\$				
<b>FS 38 You can authorize someone else in your household or someone outside your household to pick up your food stamps or to use them to buy food for you. If you would like to authorize someone, complete below:</b>					<input type="checkbox"/> F.S. I.D. Issued	
NAME OF AUTHORIZED REPRESENTATIVE	ADDRESS	PHONE				
		(   )				

<p><b>CA 39 MC</b> Did anyone get medical/pregnancy treatment this month or in the three months before this month? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>          If "YES", complete below:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;">NAME OF PERSON RECEIVING CARE</th> <th style="width: 20%;">MONTHS OF CARE</th> <th colspan="2" style="width: 20%;">PAYMENTS MADE FOR CARE</th> <th colspan="2" style="width: 20%;">DO YOU WANT MEDICAL FOR THOSE MONTHS?</th> </tr> <tr> <td></td> <td></td> <td>YES</td> <td>NO</td> <td>YES</td> <td>NO</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	PAYMENTS MADE FOR CARE		DO YOU WANT MEDICAL FOR THOSE MONTHS?				YES	NO	YES	NO													<p align="center"><b>COUNTY USE ONLY</b></p> <p><b>Retroactive Application</b></p> <p><input type="checkbox"/> Retro Only</p> <p><input type="checkbox"/> Retro and Cont.</p> <p><input type="checkbox"/> MC 210A</p>										
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		YES	NO	YES	NO																														
<p><b>CA 40 FS MC</b> Does anyone have MEDICARE coverage? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>          If "YES", complete below:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th rowspan="2" style="width: 25%;">PERSON COVERED</th> <th rowspan="2" style="width: 25%;">MEDICARE CLAIM NUMBER</th> <th colspan="4" style="width: 50%;">(✓) HOW MONTHLY PREMIUM IS PAID</th> </tr> <tr> <th>FOR</th> <th>DEDUCTED FROM CHECK</th> <th>OUT OF POCKET</th> <th>OTHER</th> </tr> <tr> <td></td> <td></td> <td>Part A</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td>Part B</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td>Part A</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td>Part B</td> <td></td> <td></td> <td></td> </tr> </table>	PERSON COVERED	MEDICARE CLAIM NUMBER	(✓) HOW MONTHLY PREMIUM IS PAID				FOR	DEDUCTED FROM CHECK	OUT OF POCKET	OTHER			Part A						Part B						Part A						Part B				<p><input type="checkbox"/> MEDICARE referral</p> <p>FS: <input type="checkbox"/> DFA 285-C          Gross Premium \$ _____</p> <p><input type="checkbox"/> QMB</p> <p><input type="checkbox"/> SLMB/QI</p> <p><input type="checkbox"/> QDWI</p>
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<p><b>CA 41 MC</b> Does anyone have health, dental, vision, hospitalization or Long Term Care insurance or health plans, such as Kaiser, Blue Cross, CHAMPUS, etc.? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>          If "YES", complete below:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 25%;">INSURANCE COMPANY</th> <th style="width: 25%;">PERSON INSURED</th> <th style="width: 15%;">EXPIRATION DATE</th> <th style="width: 15%;">PREMIUM AMOUNT</th> <th style="width: 20%;">HOW OFTEN PAID</th> </tr> <tr> <td></td> <td></td> <td></td> <td>\$</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>\$</td> <td></td> </tr> </table>	INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID				\$					\$		<p>State Certified LTC Policy: <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></p> <p><input type="checkbox"/> DHS 6155</p> <p>Benefits Paid Out \$ _____</p>																			
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			\$																																
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<p><b>CA 42 MC</b> Does anyone have any health insurance available from a parent, employer, or absent parent, which has not been applied for? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>          If "YES", complete below:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 25%;">INSURANCE COMPANY</th> <th style="width: 25%;">PERSON TO BE INSURED</th> <th style="width: 15%;">PREMIUM AMOUNT</th> <th style="width: 20%;">HOW OFTEN PAID</th> </tr> <tr> <td></td> <td></td> <td>\$</td> <td></td> </tr> <tr> <td></td> <td></td> <td>\$</td> <td></td> </tr> </table>	INSURANCE COMPANY	PERSON TO BE INSURED	PREMIUM AMOUNT	HOW OFTEN PAID			\$				\$		<p><input type="checkbox"/> DHS 6155</p>																						
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		\$																																	
<p><b>CA 43 MC</b> Is anyone's health insurance expected to end or has it ended within the last 60 days? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>          If "YES", complete below:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 25%;">INSURANCE COMPANY</th> <th style="width: 25%;">PERSON INSURED</th> <th style="width: 15%;">EXPIRATION DATE</th> <th style="width: 15%;">PREMIUM AMOUNT</th> <th style="width: 20%;">HOW OFTEN PAID</th> </tr> <tr> <td></td> <td></td> <td></td> <td>\$</td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td>\$</td> <td></td> </tr> </table>	INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID				\$					\$		<p><input type="checkbox"/> DHS 6155</p>																			
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			\$																																
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<p><b>CA 44 MC</b> Does anyone have a disability caused by injury or accident which makes it difficult for them to work or take care of their needs? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>          If "YES", complete below:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 25%;">NAME OF PERSON</th> <th style="width: 25%;">TYPE OF PROBLEM</th> <th style="width: 15%;">DATE PROBLEM STARTED</th> <th style="width: 20%;">EXPECTED DATE OF RECOVERY</th> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>	NAME OF PERSON	TYPE OF PROBLEM	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY									<p><input type="checkbox"/> Third Party Liability</p>																						
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<p><b>CA 45 FS</b> A. Does anyone have a medical condition(s) or situation(s) that requires any of the following? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>          Check (✓) each item "YES" or "NO":</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;"></th> <th style="width: 10%;">YES</th> <th style="width: 10%;">NO</th> <th style="width: 30%;"></th> <th style="width: 10%;">YES</th> <th style="width: 10%;">NO</th> </tr> <tr> <td>Special diet-prescribed by a doctor</td> <td></td> <td></td> <td>Very high use of utilities</td> <td></td> <td></td> </tr> <tr> <td>Special transportation need</td> <td></td> <td></td> <td>Special laundry service</td> <td></td> <td></td> </tr> <tr> <td>Special telephone or other equipment</td> <td></td> <td></td> <td>Other (specify):</td> <td></td> <td></td> </tr> <tr> <td>Housework (no one in the home can do it)</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table> <p>If "YES", explain:</p>		YES	NO		YES	NO	Special diet-prescribed by a doctor			Very high use of utilities			Special transportation need			Special laundry service			Special telephone or other equipment			Other (specify):			Housework (no one in the home can do it)						<p>Verified: <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></p> <p>Special Need: <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></p> <p>Amount: \$ _____</p>				
	YES	NO		YES	NO																														
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<p><b>CA 45 FS</b> B. Is there a child or disabled person in the household who needs care from another household member? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>          If "YES", explain:</p>	<p><input type="checkbox"/> Receipts</p> <p><input type="checkbox"/> MC 272 <span style="float: right;"><input type="checkbox"/> MC 273</span></p>																																		
<p><b>CA 45 FS</b> C. Is anyone a disabled person who is working and who has medical expenses (wheelchair, etc.), which are needed for the person to be able to work? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>          If "YES", complete below:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;">NAME OF PERSON</th> <th style="width: 40%;">TYPE OF EXPENSE</th> <th style="width: 30%;">AMOUNT</th> </tr> <tr> <td></td> <td></td> <td>\$</td> </tr> <tr> <td></td> <td></td> <td>\$</td> </tr> </table>	NAME OF PERSON	TYPE OF EXPENSE	AMOUNT			\$			\$	<p><input type="checkbox"/> IRWE (QMB and SGA)</p> <p>FS: <input type="checkbox"/> DFA 285-C</p>																									
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<p><b>CA 45 FS</b> D. Is anyone getting In-Home Supportive Services (IHSS)? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>          If "YES", who gets service? _____ How much do you pay each month? \$ _____</p>																																			

		Page 12 of 14																																																	
CA	(46)	Does the household want to apply for a special need payment for housing or essential household items lost or damaged due to sudden and unusual circumstances, such as an earthquake, fire, or flood? If "YES", explain below:	<div style="text-align: right;"> <input type="checkbox"/> YES <input type="checkbox"/> NO           </div> <div style="border: 1px solid black; padding: 2px;"> <b>COUNTY USE ONLY</b>  <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%; border-bottom: 1px solid black;">Special Need Verified</td> <td style="width: 20%; text-align: center;">YES NO</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Eligible for Special Need</td> <td style="text-align: center;">YES NO</td> </tr> </table> </div>	Special Need Verified	YES NO	Eligible for Special Need	YES NO																																												
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Eligible for Special Need	YES NO																																																		
CA FS	(47)	Is any member of the household avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of probation or parole? If "YES", give name of the person:	<div style="text-align: right;"> <input type="checkbox"/> YES <input type="checkbox"/> NO           </div>																																																
CA FS	(48)	Has any member of the household been convicted of a drug-related felony for possession, use, or distribution of a controlled substance(s)? Give facts for cash aid, for convictions on or after 1/1/98; and for food stamps, for crimes and convictions after 8/22/96. If "YES", complete below:	<div style="text-align: right;"> <input type="checkbox"/> YES <input type="checkbox"/> NO           </div>																																																
		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; border-bottom: 1px solid black;">NAME OF PERSON CONVICTED</td> <td style="width: 33%; border-bottom: 1px solid black;">DATE CONVICTED</td> <td style="width: 33%; border-bottom: 1px solid black;">DATE CRIME COMMITTED</td> </tr> </table>	NAME OF PERSON CONVICTED	DATE CONVICTED	DATE CRIME COMMITTED																																														
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CA MC	(49)	The following services are available. Your answers to these questions will not affect your eligibility. Check (✓) each item "YES" or "NO."	<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 60%;"></th> <th style="width: 10%; text-align: center;">YES</th> <th style="width: 10%; text-align: center;">NO</th> <th style="width: 20%;"></th> </tr> <tr> <td>A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.</td> <td></td> <td></td> <td><input type="checkbox"/> CHDP Brochure and Explanation Given</td> </tr> <tr> <td>• Do you want more information about CHDP Services? .....</td> <td></td> <td></td> <td>Date: .....</td> </tr> <tr> <td>• Do you want CHDP medical services? .....</td> <td></td> <td></td> <td><input type="checkbox"/> CHDP Referral</td> </tr> <tr> <td>• Do you want CHDP dental services? .....</td> <td></td> <td></td> <td><input type="checkbox"/> Social Services Referral (MCO)</td> </tr> <tr> <td>• Do you need help making appointments or with transportation to CHDP services? .....</td> <td></td> <td></td> <td></td> </tr> <tr> <td>B. Do you want more information about immunization services? .....</td> <td></td> <td></td> <td><input type="checkbox"/> Referred for Immuniz.</td> </tr> <tr> <td>C. If you are pregnant, you can get help finding a doctor, getting healthy foods, and other help. Do you want to talk to someone about this help? .....</td> <td></td> <td></td> <td> <input type="checkbox"/> Pregnant      <input type="checkbox"/> Parent or Guardian of child under 5  <input type="checkbox"/> Breastfeeding      <input type="checkbox"/> Postpartum           </td> </tr> <tr> <td>D. Are you breastfeeding a child? .....</td> <td></td> <td></td> <td><input type="checkbox"/> WIC referral</td> </tr> <tr> <td>    If "YES", have you given birth within the last 12 months? .....</td> <td></td> <td></td> <td></td> </tr> <tr> <td>    If you checked "YES" to (49) C or D, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC)</td> <td></td> <td></td> <td></td> </tr> <tr> <td>E. Do you or any family member want free or low-cost family planning services to help plan how to prevent unplanned pregnancies and/or have the next child? If "YES", call your health care plan or regular doctor. Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054</td> <td></td> <td></td> <td> <input type="checkbox"/> Family Planning Information Given  <input type="checkbox"/> Referred Date: .....           </td> </tr> </table>		YES	NO		A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.			<input type="checkbox"/> CHDP Brochure and Explanation Given	• Do you want more information about CHDP Services? .....			Date: .....	• Do you want CHDP medical services? .....			<input type="checkbox"/> CHDP Referral	• Do you want CHDP dental services? .....			<input type="checkbox"/> Social Services Referral (MCO)	• Do you need help making appointments or with transportation to CHDP services? .....				B. Do you want more information about immunization services? .....			<input type="checkbox"/> Referred for Immuniz.	C. If you are pregnant, you can get help finding a doctor, getting healthy foods, and other help. Do you want to talk to someone about this help? .....			<input type="checkbox"/> Pregnant <input type="checkbox"/> Parent or Guardian of child under 5 <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Postpartum	D. Are you breastfeeding a child? .....			<input type="checkbox"/> WIC referral	If "YES", have you given birth within the last 12 months? .....				If you checked "YES" to (49) C or D, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC)				E. Do you or any family member want free or low-cost family planning services to help plan how to prevent unplanned pregnancies and/or have the next child? If "YES", call your health care plan or regular doctor. Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054			<input type="checkbox"/> Family Planning Information Given <input type="checkbox"/> Referred Date: .....
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# CERTIFICATION

## I understand that:

- Any facts I gave, including benefit and income facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and unemployment agencies, school attendance, etc. And for cash aid and food stamps, records will be matched with law enforcement agencies for arrest warrants.
- All facts, including benefit and income facts, I gave may be reviewed and checked out by county, state, and federal personnel, and that if I gave wrong facts, my cash aid, food stamps, and Medi-Cal may be denied or stopped.
- My case may be picked for reviews to ensure that my eligibility was correctly figured and that I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.
- The county will send facts to the Immigration and Naturalization Service (INS) to verify immigration status and the facts the county gets from INS may affect my eligibility for cash aid, food stamps, and full Medi-Cal. But if I am applying for Medi-Cal Only, AND if I am not (a) a lawful permanent resident noncitizen (LPR), (b) an amnesty alien with a valid and current I-688, or (c) a noncitizen permanently residing in the United States under color of law (PRUCOL), the county will not send facts to the INS.
- I must apply for and keep any available health coverage if no cost is involved; if I do not my Medi-Cal will be denied or stopped.
- I or other family members will be required to repay any cash aid I should not have received.
- The Food Stamp household, any adult member of a Food Stamp household (even if he/she moves out), the sponsor of a noncitizen household member or the authorized representative of residents in an eligible institution may be required to repay any benefits the household should not have received.
- Any member of my household who is avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of their parole or probation cannot get cash aid or food stamps.
- Anyone who has committed and been convicted of a drug-related felony for possession, use, or distribution of a controlled substance(s) since August 22, 1996, cannot get food stamps or if convicted on or after January 1, 1998, cannot get cash aid.
- For cash aid and food stamps, the county will require that I and certain household members be fingerprint and photo imaged. My benefits may be denied or stopped if I do not cooperate.

## I also understand that:

I will get disqualification and/or welfare fraud penalties if on purpose I give wrong facts or fail to report all facts or situations that affect my eligibility or benefits for cash aid, food stamps, and Medi-Cal.

### For cash aid:

- If I on purpose do not follow cash aid rules, I may be fined up to \$10,000 and/or sent to jail/prison for 3 years. And my cash aid can be stopped:
  - For not reporting all facts or for giving wrong facts: 6 months for the first offense, 12 months for the second, or forever for the third; and for Refugee Cash Assistance, 3 months for the first and 6 months for any later offense.
  - For submitting one or more applications to get aid in more than one case at the same time: 2 years for the first conviction, 4 years for the second, or forever for the third.
  - For conviction of felony thefts to get aid: 2 years for theft of amounts under \$2000; 5 years for amounts of \$2000 through \$4999.99; and forever for amounts of \$5000 or more.
  - For giving the county false proof of residency in order to get aid in two or more counties or states at the same time; giving the county false proof for an ineligible child or a child that does not exist; getting more than \$10,000 in cash benefits through fraud; getting a third conviction for fraud in a court of law or an administrative hearing: forever.

### For food stamps:

- If on purpose I do not follow food stamp rules, my food stamps will be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And I may be fined up to \$250,000 and/or sent to jail/prison for 20 years.
- If I am found guilty in any court of law because:
  - I traded or sold food stamps for firearms, ammunition, or explosives, my food stamps can be stopped forever for the first violation.
  - I traded or sold food stamps for controlled substances, my food stamps can be stopped for 24 months for the first violation and forever for the second.
  - I traded or sold food stamps that were worth \$500 or more, my food stamps can be stopped forever.
  - I filed two or more applications for food stamps at the same time and gave the county false identity or residence information, my food stamps can be stopped for 10 years.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information in this statement of facts is true, correct, and complete.

SIGNATURE (PARENT OR CARETAKER RELATIVE, MEDI-CAL APPLICANT, ADULT FOOD STAMP HOUSEHOLD MEMBER OR FOOD STAMP AUTHORIZED REPRESENTATIVE)		DATE	
SIGNATURE (OTHER PARENT LIVING IN THE HOME, IF APPLYING FOR CASH AID)		DATE	SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON ACTING FOR APPLICANT/BENEFICIARY
			DATE

COUNTY USE ONLY															
ELIGIBILITY FACTORS REVIEWED						ELIGIBILITY FACTORS REVIEWED						FOOD STAMP TESTS			
												YES	NO	NA	
	CA	FS	MC				CA	FS	MC						
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO			
Residency							Property/Resources—Within limits								
Deprivation							Work participation								
Age							FSET								
Immunizations							ABAWDs								
Citizen/Eligible noncitizen							CFAP								
School enrollment							Sponsored noncitizen								
Pregnancy verif./ WIC Referral							Federal participation established (If "NO", explain)								
SSN							Referred for Health Care Options (HCO) Presentation								
Income—Applicant/Recipient test(s)															
SFIS															
TANF Time Limits															
CalWORKs Time Limits															

COMMENTS

AU Size:		Non-AU Size:		AU/MFBU Size:		FS:		HH Size:	
<input type="checkbox"/> INELIGIBLE (REASON):						<input type="checkbox"/> INELIGIBLE (REASON):			
<input type="checkbox"/> ELIGIBLE <input type="checkbox"/> DIVERSION <input type="checkbox"/> REDETERMINATION <input type="checkbox"/> EXEMPT MAP						<input type="checkbox"/> ELIGIBLE <input type="checkbox"/> RECERTIFICATION			
AUTHORIZATION DATE						AUTHORIZATION DATE			
EFFECTIVE DATE									
WORKER'S SIGNATURE						WORKER'S SIGNATURE			
DATE						DATE			
SUPERVISOR'S SIGNATURE (COUNTY OPTION)						SUPERVISOR'S SIGNATURE (COUNTY OPTION)			
DATE						DATE			

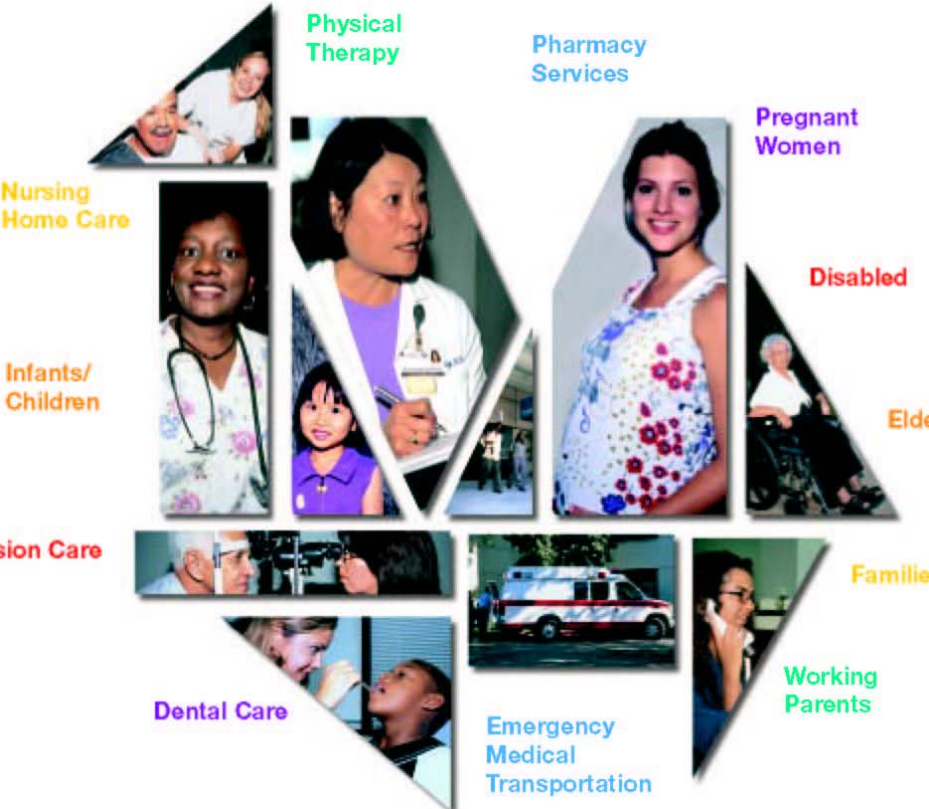
Online Version: [www.dhs.ca.gov/mcs/medi-calhome/MC210.htm](http://www.dhs.ca.gov/mcs/medi-calhome/MC210.htm)

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**HEALTH CARE COVERAGE**  
**FOR PEOPLE WITH LIMITED INCOME OR RESOURCES**

**MEDI-CAL**

**NEW MAIL-IN APPLICATION AND INSTRUCTIONS**



Physical Therapy

Pharmacy Services

Pregnant Women

Nursing Home Care

Infants/Children

Elder Care

Vision Care

Dental Care

Emergency Medical Transportation

Families

Working Parents

Disabled

For **FREE** help to apply for Medi-Cal,  
contact your local welfare office.

### What is Medi-Cal?

- Health care coverage for qualifying persons who live in California, who have income and resources below established limits



### Who can get Medi-Cal?

- Persons 65 or older or
- Persons who are under 21 years of age
- Certain adults, between 21 and 65 years of age, if they have minor children living with them
- Persons who are blind or disabled
- Pregnant women
- Persons receiving nursing home care
- Certain Refugees, Asylees, Cuban/Haitian Entrants

### Do I have to be a U.S. citizen to get Medi-Cal?

- No, documented and undocumented aliens may be eligible for Medi-Cal. Some persons may receive pregnancy related and emergency services only; others are eligible for full Medi-Cal benefits depending on their alien status

### When Medi-Cal says "a minor child," what does it mean?

- A child married or unmarried under 21 years of age living in your home or away at school

### What do I do to get Medi-Cal coverage?

- Complete and send in the enclosed application
- Send copies of any required documentation (See instructions)

### How can my family and I qualify for Medi-Cal coverage?

If you are in one of the groups listed in "Who can get Medi-Cal?" above:

- We look at your income and subtract some expenses you pay to decide your family's countable income for Medi-Cal
- We look at things you and your family own (bank accounts, vehicles, etc.) to see if you meet the resource limit. **Please Note:** Not all the things you or your family own are counted; your local welfare office can give you more information



### If I do not fall into one of the covered groups, how can I get coverage?

- Contact your local welfare office for information about medical services in your county

MC 210 08/01  
INSTRUCTIONS

## **When Applying For Medi-Cal Health Coverage**

### **What Should I Do If...**

***I have an immediate need for health care services, such as severe illness or pregnancy.***

- Take this application directly to the nearest welfare office to start the application process.

***I filled out the application and want to mail it.***

- Complete the application and mail it to your nearest local welfare office.

***I have the application, but need help.***

- Read Instructions carefully.
- Contact your local welfare office for help.
- Ask a friend or relative to help you.

***I'm homeless or do not have a mailing address.***

***DO NOT MAIL THIS APPLICATION.***

- Go to the nearest local welfare office to turn in this application.



***My spouse or I are entering a nursing home and applying for Medi-Cal.***

- Immediately contact your local welfare office for a copy of the notice regarding standards for Medi-Cal eligibility form (DHS 7077). This form will explain certain exempt resources, certain protections against spousal impoverishment, and certain circumstances under which an interest in a home may be transferred without affecting Medi-Cal eligibility.

***I'm a minor/teenager and want confidential Minor Consent Services, for family planning, pregnancy related care, mental health, drug and alcohol abuse treatment/ counseling, sexually transmitted diseases (STD) or sexual assault.***

- To maintain confidentiality, you must take this application to the local welfare office or eligibility worker site.

***DO NOT MAIL IT.***

***I want to ask for Medi-Cal in person. I do not want to mail the application.***

- Contact your local welfare office and ask for an interview to apply in person.

**Remember, whether you take your application to the local welfare office or you mail it, you should **not pay** anyone to help you with this application.**

**[www.dhs.ca.gov](http://www.dhs.ca.gov)**

.....  
**For **FREE** help to apply for Medi-Cal,  
contact your local welfare office.**

## ***How to fill out the application***

- **Tear out the application**
- **Read the instructions completely**
- **Fill out as much of the application as you can**
- **Include requested documentation (See instructions)**
- **If help is needed contact the local welfare office**
- **Do not delay in sending in your application**

## **Whose information should you put on this application?**

- If you are an adult not living with a spouse, and you have no children, enter your own information.
- If you are legally married and living together, enter your and your spouse's information.
- If you are legally married but one or both of you are living in a nursing home or board and care facility, enter your and your spouse's information.
- If your children are under 21 years of age and living with you and their other parent, enter your own information, your children's and the other parent's.
- If you are under 21 years of age and not living with your parents, enter your own information.
- If you are an unmarried minor under 21 years of age living with your parent(s) and asking for Minor Consent confidential services, enter your own information.



## **What will happen after I send in my application?**

- The local welfare office will notify you within 10 working days that they received your application. They will give you the name of someone you can contact for more information about your application.
- You will receive a packet from the county with additional program information.
- You may receive a request for additional information that the county will need in order to determine your eligibility.
- In most instances the local welfare office will determine your eligibility within 45 days and notify you in writing of that decision. An eligibility determination based on disability may take up to 90 days.
- If you are determined eligible, depending on what county you live in, you may be able to choose a health plan by completing a separate enrollment form.
- If you do not qualify for no-cost Medi-Cal and you wish to apply for the Healthy Families program, the local welfare office will forward this application to that program.

MC 210 08/01  
INSTRUCTIONS

State of California - Health and Human Services Agency

Department of Health Services

## APPLICATION FOR MEDI-CAL

To complete this form, use the instructions. Print clearly. Use black or blue ink only.

**SECTION 1** Tell us about the person who wants Medi-Cal for themselves, their family or children in their care.

<b>1</b> LAST NAME	FIRST NAME	MIDDLE INITIAL
<b>2</b> HOME ADDRESS (NUMBER AND STREET). DO NOT LIST A P.O. BOX UNLESS HOMELESS		<b>3</b> APARTMENT NUMBER
		<b>4</b> HOME PHONE # ( )
<b>5</b> CITY	<b>6</b> COUNTY/STATE	<b>7</b> ZIP CODE
		<b>8</b> WORK PHONE # ( )
<b>9</b> MAILING ADDRESS (IF DIFFERENT FROM ABOVE) OR P.O. BOX		<b>10</b> APARTMENT NUMBER
		<b>11</b> MESSAGE PHONE # ( )
<b>12</b> CITY		<b>13</b> ZIP CODE
<b>14A</b> WHAT LANGUAGE/DIALECT DO YOU SPEAK BEST?		<b>14B</b> WHAT LANGUAGE DO YOU READ BEST?

**SECTION 2** Tell us about the person listed in Section 1, his or her family and the children they care for, even if they don't want coverage.

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
<b>15</b> Name:					
Last					
First					
Middle					
<b>16</b> Relationship to person in Section 1.					
<b>17</b> If address where living is not the same as listed in Section 1, put address where living:					
<b>18</b> Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>19</b> Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
<b>20</b> Name of spouse(s) of married minors in the home.					
<b>21</b> Date of Birth:	MO / DAY / YR	MO / DAY / YR	MO / DAY / YR	MO / DAY / YR	MO / DAY / YR
<b>22</b> Pregnant:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Due Date:</b>	MO / DAY / YR	MO / DAY / YR	MO / DAY / YR	MO / DAY / YR	MO / DAY / YR
<b>23</b> Has a physical, mental or emotional disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Disability expected to last:</b>	<input type="checkbox"/> 30 Days or More <input type="checkbox"/> 12 Months or More	<input type="checkbox"/> 30 Days or More <input type="checkbox"/> 12 Months or More	<input type="checkbox"/> 30 Days or More <input type="checkbox"/> 12 Months or More	<input type="checkbox"/> 30 Days or More <input type="checkbox"/> 12 Months or More	<input type="checkbox"/> 30 Days or More <input type="checkbox"/> 12 Months or More

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**SECTION 2** Continued

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
24 Has any one ever received cash aid, SSI, Food Stamps or Medi-Cal?	Yes No	Yes No	Yes No	Yes <input type="checkbox"/> No	Yes No
If "Yes," under what name?					
25 Medi-Cal benefits BIC card number, if you have it:					
26 Wants Medical benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
27 Do you own or are you buying a home outside California?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 3** Answer for **all** children in Section 2.

28 Mother's Name:	Mother's Name:	Mother's Name:	Mother's Name:
Is Mother: Employed Disabled Unemployed Deceased Absent	Is Mother: Employed Disabled Unemployed Deceased Absent	Is Mother: Employed Disabled Unemployed Deceased Absent	Is Mother: Employed Disabled Unemployed Deceased Absent
29 Father's Name:	Father's Name:	Father's Name:	Father's Name:
Is Father: Employed Disabled Unemployed Deceased Absent	Is Father: Employed Disabled Unemployed Deceased Absent	Is Father: Employed Disabled Unemployed Deceased Absent	Is Father: Employed Disabled Unemployed Deceased Absent

**SECTION 4** List **all** income/money received by persons listed in Section 2.

30 NAME OF PERSON RECEIVING INCOME/MONEY	31 SOURCE OF INCOME/MONEY RECEIVED (Employment, social security)	32 HOW MUCH INCOME/MONEY IS RECEIVED	33 HOW OFTEN INCOME/MONEY RECEIVED (Monthly, bimonthly, weekly, biweekly, daily)

**SECTION 5** Give information about the listed expenses/cost paid by **all** persons listed in Section 2.

TYPE OF PAYMENT YOUR FAMILY MAKES	34 NAME OF PERSON WHO PAYS	35 MONTHLY AMOUNT PAID	36 CHILD CARE OR DEPENDENT CARE (List child's or dependent's name)	37 AGE	38 NAME OF PERSON WHO PAYS	39 MONTHLY AMOUNT PAID
Child Support			1.			
Alimony			2.			
Other Health Insurance Premium			3.			
Medicare Premium			4.			

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TEAR HERE

**SECTION 6** Skip this Section if you are **only** applying for children under 19 and/or pregnant women (pregnancy related services only).Otherwise answer for **all** persons listed in Section 2.

40	Does anyone have cash or uncashed checks? If "Yes," list amount here _____ (See instructions)	<input type="checkbox"/> Yes <input type="checkbox"/> No
41	Does anyone have a checking, savings account, or life insurance? (See instructions)	<input type="checkbox"/> Yes <input type="checkbox"/> No
42	Is there one car or more in the household? (See instructions)	<input type="checkbox"/> Yes <input type="checkbox"/> No
43	Does anyone have a court ordered settlement or judgement? (See instructions)	<input type="checkbox"/> Yes <input type="checkbox"/> No
44	Does anyone have Long-Term Care insurance? (See instructions)	<input type="checkbox"/> Yes <input type="checkbox"/> No
45	Does anyone own any items such as stocks, bonds, retirement funds, trusts, real estate, motor vehicles for a business, business accounts, promissory notes, mortgages, deeds of trust, recreational vehicles, burial trusts or funds, annuities, jewelry (not heirloom or wedding), oil or mineral rights? (See instructions)	<input type="checkbox"/> Yes <input type="checkbox"/> No
46	Has anyone listed on this form, transferred, sold, traded or given away any items such as those listed above in the last 30 months? (See instructions)	<input type="checkbox"/> Yes <input type="checkbox"/> No
47	Have any items listed in this section been spent or used as security for medical costs? (See instructions)	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 7** Answer **only** for persons who want Medi-Cal.

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
48 Social Security #:					
You may be able to receive Medi-Cal even if you do not have a Social Security Number.					
49 Place of Birth: <i>State or Country</i>					
50 U.S. Citizen or National? If "No," write in date of entry into U.S.	<input type="checkbox"/> Yes <input type="checkbox"/> No / / MO DAY YR	<input type="checkbox"/> Yes <input type="checkbox"/> No / / MO DAY YR	<input type="checkbox"/> Yes <input type="checkbox"/> No / / MO DAY YR	<input type="checkbox"/> Yes <input type="checkbox"/> No / / MO DAY YR	<input type="checkbox"/> Yes <input type="checkbox"/> No / / MO DAY YR
51 Living in a Long-Term Care or Board and Care Facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," name of facility:					
Do you intend to return home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No
Do you intend to return home within six months?	Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No
52 Has health/dental or vision coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No
53 Had medical expenses within the 3 months before the month you applied and want Medi-Cal for those expenses.	Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No
54 Lawsuit pending due to accident or injury?	Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

TEAR HERE

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**SECTION 7** Continued

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
55 Current or past U.S. Military Service for adults, spouse or child's parents?	Yes No <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	Yes <input type="checkbox"/> No Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	Yes No <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	<input type="checkbox"/> Yes No Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	<input type="checkbox"/> Yes No Self Spouse Parent
56 Ethnicity (race): (optional)					
57 In school full time?	Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No	Yes No	Yes No	Yes No
58 Living away from home?	Yes No	Yes <input type="checkbox"/> No	Yes No	Yes No	Yes No

**SECTION 8** Information Release (Optional).

59 If family member cannot get no-cost Medi-Cal but may be able to get low-cost health care coverage, can the local welfare office send this form to the Healthy Families Program? ☐ Yes ☐ No

60 I got help from (give name of person) \_\_\_\_\_ when I filled out this application. I agree that the local welfare office may give them information about the status of this application. **Applicant please initial** \_\_\_\_\_

**SECTION 9** Signature and Certification.

61 I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application, and the documents given are correct and true to the best of my knowledge and belief.  
I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature (if person signed with a mark) \_\_\_\_\_ Date \_\_\_\_\_

Signature of person helping Applicant fill out the form Telephone Number Relationship to Applicant Date

Signature of person acting for Applicant/Beneficiary Telephone Number Relationship to Applicant Date

**For information about any of the following programs, check the box(es) below and information will be sent to you. See the Medi-Cal brochure, "Health Care for Families with Children" or visit our website, [www.dhs.ca.gov](http://www.dhs.ca.gov)**

Personal Care Service Program (PCSP). A program for in-home care.

Access for Infants, and Mothers (AIM). A program to help pregnant women with moderate income obtain health care.

Woman, Infants and Children Nutrition Program (WIC). A nutrition program for pregnant and postpartum women and children under 5.

Family Planning

Child Health and Disability Program (CHDP). Preventive healthcare for children and youth.

Do you want your children or youth referred to the CHDP program? Yes No

## INSTRUCTIONS

**Please read before beginning application.**

### SECTION 1

**Tell us about the person who wants Medi-Cal for themselves, their family or children in their care.**

#### Question 1:

Enter the name of the person who wants Medi-Cal, or the parent/caretaker of the children who want Medi-Cal.

#### Questions 2-8:

Enter the address and telephone numbers of the person who wants Medi-Cal.

#### Questions 9-13:

Enter the phone number and mailing address (if different than home address provided in #2) of the person who wants Medi-Cal. This is the address where all information regarding the application and health benefits will be mailed.

#### Question 14A-B:

Enter the language you speak and/or read best.

**Send proof of identity.** Only one person (a parent or caretaker) in a family needs to provide an identity document. Send a **photocopy** of one of the following identity items:

- California driver license
- Identification card issued by the Department of Motor Vehicles
- U.S. citizenship or alien status documents (passport).
- School identification card
- Birth certificate
- Marriage record
- Social Security card or document containing a Social Security number.
- Divorce decree
- Work badge, building pass
- Adoption record
- Court order for name change
- Church membership or baptismal confirmation certificate

### Identity proof is not needed for

- Persons in an institution
- Children in a family, if identity of one parent has been established
- Children requesting Medi-Cal for Minor Consent services
- The spouse of a person whose identity has been verified

### SECTION 2

**Tell us about the person listed in Section 1, whether or not they want Medi-Cal, his or her family and the children they care for.**

*If you are applying for more than 5 people, use a separate piece of paper or a photocopy of pages A1, A2, A3 and A4 of the application, to give us information about the additional persons.*



### Who counts as an adult?

- Persons 21 years of age or older
- Persons under 21 years of age who is not living in the home of their parent or caretaker relative and is not claimed as a tax dependent

### Who counts as children?

- All natural and adoptive children under 21 living in the home
- All natural and adoptive children between 18 and 21 years of age, away from home and claimed as a tax dependent
- All stepchildren under age 21 living in the home

#### Question 15:

Write the last, first and middle name of each person in the house.

## SECTION 2 Continued

### Question 16:

How is each person related to the person in Section 1. *Example: self, wife, husband, grandparents, friend, daughter, stepchild, nephew, etc.*

### Question 17:

Write the complete address, if different from the address in Section 1. *Example: child is in college and living at school.*

### Question 18:

Indicate gender of each person.

### Question 19:

Indicate the marital status of each person listed.

### Question 20:

Write the name of the spouse of any married minors living in the home. Any income of the spouse must be listed in Section 4.

### Question 21:

Write month, day and year of birth for each person.

### Question 22:

Tell us if this person is pregnant. If "Yes," tell us the due date.

Send proof of pregnancy from a Doctor's office or a clinic within 60 days to continue receiving full Medi-Cal benefits. You do not need to send verification if you only want pregnancy related services.

### Question 23:

Check "Yes," if person is blind or has a physical or mental illness that is expected to last at least 30 days. If person is unable to work, check "Yes," and check the box that best describes how long the person will be unable to work if declared disabled. This will help us decide if you are eligible for Medi-Cal based on disability.

### Question 24:

Tell us if anyone has ever had cash aid, SSI, Food Stamps or Medi-Cal. This will help the local welfare office check for needed information before asking you to give it. If you checked "Yes," tell us the name you received benefits under.

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### Question 25:

If you have ever received Medi-Cal, tell us your Medi-Cal Benefits Identification Card (BIC) number if you have it.

Your Medi-Cal Benefits Identification Card (BIC) number can be found here.



### Question 26:

Check "Yes," if you are asking for medical benefits for this person.

### Question 27:

Tell us if you own or are buying a home outside California. Your answer helps us determine your residency.

**Send proof of California residency.** You can use your proof of income as proof of residency, too. If your income is not from California, send other proof of residence. For example: rent receipts, utility bill or a child's school records.

## SECTION 3

### Answer for **all** children in Section 2.

### Question 28:

Write the name of the natural or adoptive mother of each child. Check the box to tell us if the mother is employed, disabled, unemployed, deceased or absent from the home.

### Question 29:

Write the name of the natural or adoptive father of each child. Check the box to tell us if the father is employed, disabled, unemployed, deceased or absent from the home.



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English

## SECTION 5

**Give information about the listed expenses/costs paid by *all* persons listed in Section 2.**

Tell us if you pay court-ordered **child support**, or **alimony**, or have other **health insurance** or **Medicare** premium costs.

Medi-Cal will pay your medicare premiums and deduct the cost of any other insurance premium from your countable income.

### Question 34:

Write the name of the person who pays the cost.

### Question 35:

Write in the total amount paid each month.

### Question 36:

Write in the costs paid for child care and/or disabled dependent care.

### Question 37:

List the age of the child or disabled dependent.

### Question 38:

Write the name of the person who pays the cost.

### Question 39:

List the total amount paid monthly for each child or disabled dependent.



**Send proof of expenses (costs) listed in Section 5. Send in proof of child support or alimony costs. For childcare and dependent care, send receipts or cancelled checks.**

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## SECTION 6

**Skip this section if you are only applying for Children under 19 and/or pregnant women applying for pregnancy related services only. Otherwise answer for *all* persons listed in Section 2.**

***If you have questions or concerns about completing Section 6, leave it blank and contact the local welfare office for help.***

***The value of the home you are living in is not counted for Medi-Cal***

### Question 40:

Tell us the amount of all cash you have on hand and the amount of any checks you have received but not cashed.

### Question 41:

If anyone listed has a checking and/or savings account or life insurance policy, please send copies of the following documents:

- Account statements showing current balances in accounts.
- Copies of all life insurance policies.

### Question 42:

If you checked "Yes," send us a copy of the vehicle registration(s) or pink slip(s) or estimate(s) of value from a qualified source, such as a dealer or mechanic.

### Question 43:

If you check "Yes," send us copies of all court orders, documents and agreements.

### Question 44:

If you check "Yes," send us copies of your policies, contracts and purchase agreements. If your policy is certified by the California Partnership for Long-Term Care, give us a copy of your most recent benefit statement.

### Questions 45-47:

If you check "Yes," you may be asked to provide additional information. You may also have to fill out a property supplement form.

## SECTION 7

Answer **only** for persons who want Medi-Cal.

### Question 48:

A Social Security number for each person applying for full Medi-Cal benefits is required. If you do not have a Social Security number, do not delay sending in this application. You can apply now and give us the number within the next 60 days.

**Pregnancy and emergency care services may be available to persons who are unable to get a Social Security number.**

For information on how to apply for a Social Security number, call Social Security Administration toll-free, 1-800-772-1213.

### Question 49:

Write the place of birth for each person. If born in the United States, write the name of the state. If born outside the U.S., write the name of the country.

### Question 50:

Check "Yes" or "No," telling us if the person is a Citizen or U.S. National.

Give immigration information only for people applying for health coverage. Do not give information for people not applying. The State will use this information only for eligibility determination. Information about immigration is private and confidential.

Immigrants who meet all immigration requirements may get **full Medi-Cal benefits**. Undocumented immigrants can get pregnancy related and emergency services.



**Send proof of immigration status** or an INS receipt showing that you applied to replace a lost document. Many immigrants may get full Medi-Cal even if they do not have a green card or immigration document. Copy both sides and send now or within 30 days of application. If you do not send this proof, you may still be eligible for emergency or pregnancy related services.

Do not give immigration information about people who are not asking for Medi-Cal. Information about immigration is private and confidential.

### Question 51:

Tell us if the person is in a nursing facility, residential, or board and care facility. If you check "Yes," tell us the name of the facility.

### Question 52:

Check box to show if each person has other health insurance coverage.

You can get Medi-Cal and still have other health coverage. Medi-Cal may cover what your other health coverage does not.



## SECTION 7 Continued

### Question 53:

If you check "Yes," Medi-Cal may be able to help pay some or all of the paid or unpaid medical costs you have had in the 3 months before you apply.

### Question 54:

Check "Yes," if any person has filed a lawsuit because of an accident or injury, workers compensation, or car accident.

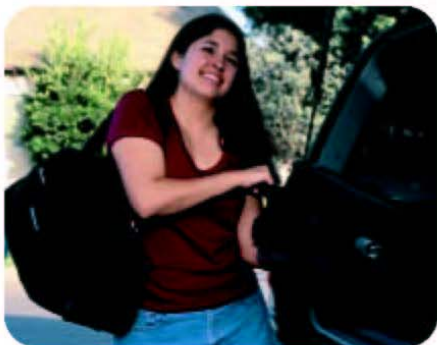


### Question 55:

Check box(es) to show if individual, spouse or parent of individual is or was in the U.S. Military. We are asking for this information to see if you can get other services or benefits.

### Question 56 (Optional):

You can choose to enter the Ethnicity (race) for each person. This information is used for statistics only and has no effect on your eligibility for Medi-Cal.



### Question 57:

Check box to show if person is in school. The earnings of a person under 21 years may not be counted if the person is attending school.

### Question 58:

Tell us if the person is living away from home, is away at school, or out of town working.

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## SECTION 8

### Information Release (Optional).

#### Question 59:

Check "Yes," and the local welfare office will send this application to the Healthy Families program, if one or more of the family members applying do not qualify for the Medi-Cal program.

The Healthy Families Program provides comprehensive health, dental, and vision coverage for eligible children and adults. For further information call **1-800-880-5305** or visit their website at [www.healthyfamilies.ca.gov](http://www.healthyfamilies.ca.gov)

#### Question 60:

If you fill out this item you are telling the local welfare office it is okay to give information about your application to the persons you have named.

## SECTION 9

### Signature and Certification.

#### Who can sign this application?

- The person who wants Medi-Cal, or the spouse of the person who wants Medi-Cal
- The conservator, guardian executor, or caretaker of a child who wants Medi-Cal
- Someone acting for the person who wants Medi-Cal when the person is incompetent, in a comatose condition, or suffering from amnesia and there is no spouse, conservator, guardian or executor
- Persons 14 to 21 years old if they are not living with a parent, caretaker relative, or foster parent
- Persons 14 to 21 requesting Minor Consent Services

#### Question 61:

State and federal laws require your signature on this application form. Your signature in this section indicates that your declarations and answers are truthful and the documents you submit are true and correct.

### Medi-Cal Confidentiality Notice

The information given in this application is private and confidential under Welfare and Institutions Code 14100.2.

The information will be disclosed only in accordance with those laws.

### Medi-Cal Rights, Responsibilities and Declarations

#### I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
- Ask for an interpreter.
- Ask for a fair hearing if I think a decision on my Medi-Cal case is unfair or wrong. I must ask for a hearing within 90 days after I get a "Notice of Action". To find out about Medi-Cal fair hearings, call toll-free, 1-800-952-5253.
- A face-to-face interview.
- Review Medi-Cal program rules and manuals.

#### I have the responsibility to:

- Report any changes within 10 days in the information I give on this application.
- Let local welfare office know if a family member applies for disability benefits; is in a public institution; or gets medical care for any accident or injury caused by another person.
- Cooperate if my case is reviewed.
- Apply for available income.
- Cooperate with appropriate paternity determinations and medical support enforcement efforts.
- Assignment of rights to medical support to the State of California.
- Assign rights to third party medical support to the State of California.

#### I understand that:

- As a condition of Medi-Cal eligibility, all rights to medical support are automatically assigned to the State of California.
- If I purposely do not give needed facts, or if I give false facts, I understand benefits may be denied or ended and repayment may be required. I may also be investigated for fraud.
- Persons I am applying for are not in jail, prison, or any other correctional facility.
- After my death, the State has the right to seek repayment from my estate for all Medi-Cal benefits I receive after age 55 unless I have a surviving spouse, minor child(ren), blind or permanently and totally disabled child(ren).
- If I am admitted to a nursing facility and I have no intention of returning to my home, the State may impose a lien against my property.

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### Medi-Cal Privacy Notice

The Information Practices Act of 1977 and the Federal Privacy Act require the Department of Health Services to provide the following information: Welfare and Institutions Code Section 14011 and regulations in Title 22, CCR, require applicants for the Medi-Cal program to provide the eligibility information requested in this application.

This information may be shared with federal, state, and local agencies for purposes of verifying eligibility and for other purposes related to the administration of the Medi-Cal program, including confirmation with the INS of the immigration status of only those persons seeking full scope Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except cases of fraud.) The information will be used to process claims and make Benefits Identification Cards (BICs). Failure to provide the required information may result in denial of the application.

Information required by this form is mandatory, with the exception of ethnicity information, and any other item marked voluntary or optional.

Social Security Numbers are required by Section 1137(a)(1) of the Social Security Act and by Welfare and Institutions Code Section 14011.2, unless applying for emergency or pregnancy related benefits only.



**An individual has a right of access to records containing his/her personal information that are maintained by the Department of Health Services.**

**Contact your local welfare office to request your records.**



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English